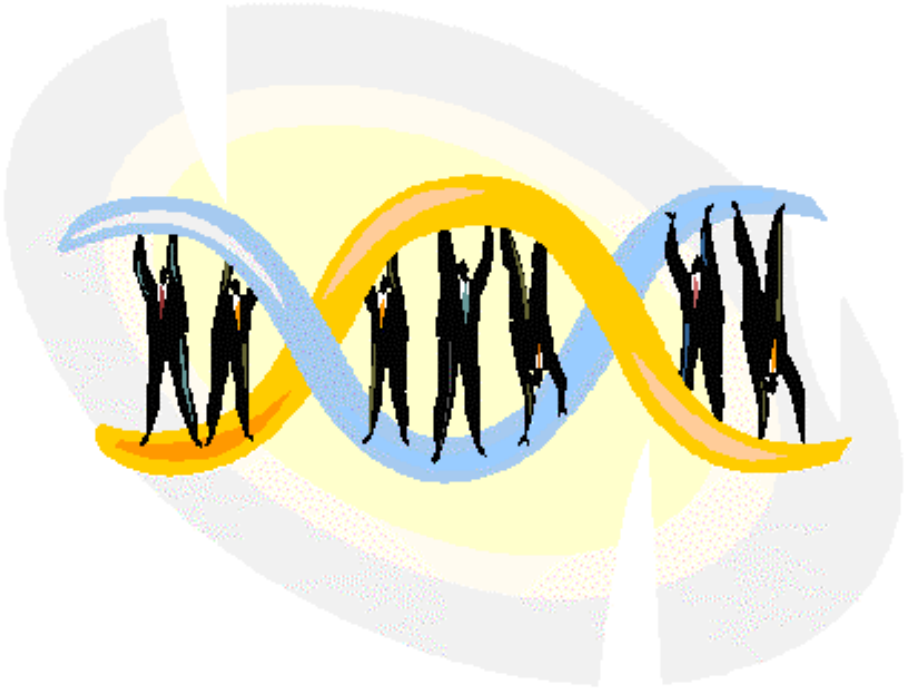
Strategic Workforce Plan

National Institutes of Health

August 2002



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I. Agency Context for Workforce Planning

A. Mission

The NIH mission is to uncover new knowledge about the prevention, detection, diagnosis, and treatment of disease and disability.

NIH works toward this mission by conducting research in its own laboratories; supporting the research of non-federal scientists in universities, medical centers, hospitals, and research institutions throughout the country and abroad; helping to train research investigators; and fostering communication of medical information.

B. Core Programs

1. Managing Extramural Research

Research Project Grants (RPGs) are the core mechanism for NIH support for the individual investigator. Other mechanisms include Program Project Grants, which support multi-disciplinary projects conducted by several collaborating investigators, and Center Grants, which are used to fund multi-disciplinary programs of medical research. Scientists working at universities, medical, dental, nursing and pharmacy schools, schools of public health, non-profit research foundations, and private industry submit research proposals to NIH. NIH support for a project includes the salaries of the scientists and technicians; the cost of equipment such as lasers or computers; the cost of supplies such as chemicals and test tubes; the cost of procedures conducted with research subjects; and the indirect costs associated with doing research, such as maintenance of buildings, electricity, library services, and cost of administrative support. Part of the NIH budget is also spent on research and development contracts that are awarded to non-profit and commercial organizations for work requested and overseen by NIH.

NIH funds are awarded through a highly competitive process to the most promising and productive scientists. Extramural research proposals are first evaluated by expert scientific peer review panels composed of non-NIH scientists who are among the most knowledgeable and respected in

their fields. The proposals are then reviewed by independent advisory councils that include members of the lay public. This two-tiered independent review system is critical to ensuring that the best research proposals are funded from the more than 40,000 grant applications NIH receives each year.

In FY 2003, NIH plans to fund a total of 9,854 competing (new) RPGs for $3,641 million. This represents an increase of 477 competing RPGs over the FY 2002 estimate of 9,377 awards. In FY 2003, total RPGs funded will be 38,038 awards, an increase of 1,408 awards over the FY 2002 Estimate of 36,630 awards, the highest annual total ever awarded. In addition, NIH will continue to fund non-competing RPGs for a total grants outlay of $14,304 million.

In addition to RPGs, NIH also proposes in FY 2003 to support Program Project Grants, Center Grants, and R&D Contracts at unprecedented levels of funding.

2. Conducting Intramural Research

NIH also conducts basic and clinical research in its own (intramural) laboratories. Projects are selected on the basis of scientific merit and public health need. Each institute maintains a Board of Scientific Counselors, composed of external experts, that reviews the intramural programs and makes recommendations to the Institute Director. The intramural program enables scientists to apply the results of laboratory research to patient care and to seek answers in the laboratory to questions that arise in the clinical setting. This national resource permits NIH to respond rapidly to critical health problems and emergencies and to take advantage of emerging opportunities.

3. Disseminating Scientific Results and Research-Based Health Information

NIH develops and disseminates informational materials to individuals and groups, including the general public, medical and scientific organizations, industry, the media, and volunteer and patient organizations. Information dissemination efforts have expedited the translation of NIH's scientific advances and technologies into important diagnostic, preventive, and therapeutic products. In addition, they have brought about major health-enhancing changes in public attitudes and behaviors, such as reduction of smoking and better control of high blood pressure and high cholesterol levels. To effectively reach diverse audiences, whose knowledge of science and health differ, NIH disseminates information ranging from highly technical research advances to the steps individuals can take to improve their own health.

NIH disseminates information on scientific findings and technologies to scientific and other health professionals through various avenues: scientific publications, workshops and symposia, scientific meetings, consensus development conferences, press releases, special physician education programs, and clinical alerts concerning immediate health and safety issues. NIH also provides access to information about scientific articles, NIH research grants, clinical trials and treatment through extensive electronic databases.

To respond to the public, Congress, and the media, NIH makes extensive use of internet technologies, information offices, clearinghouses,

electronic databases, public education programs, publications and press releases, as well as direct responses by letter and telephone. These provide information regarding participation in research protocols; the best current information on disease prevention and health promotion, diagnosis, and treatment of specific diseases and disorders; information about ongoing research; and referrals to other sources of information. One of the most important mechanisms for disseminating information is the NIH web site at www.nih.gov. The www.nih.gov site provides information on scientific research and public health topics to an average of 408,357 unique visitors per month, each spending an average of 18 minutes on the site.

4. Facilitating the Development of Health-Related Products Through Technology Transfer

NIH has a statutory mandate to transfer new biomedical technologies to the private sector for further development and commercialization. NIH's technology transfer programs ensure that the public investment in NIH research leads rapidly to beneficial health-related products, including preventives, diagnostics, therapeutics, and vaccines.

Many NIH research results are converted into commercial medical products, typically through the publicly available knowledge base created by NIH-supported research. The public also benefits from NIH technology transfer activities, including Cooperative Research and Development Agreements (CRADAs) with the private sector and the licensing to industry of intellectual property rights arising out of CRADAs and other NIH research. Virtually all NIH licenses negotiated with industry are royalty bearing.

5. Ensuring a Continuing Supply of Well-Trained Laboratory and Clinical Investigators

To support the critical medical research of the nation, it is critical that the NIH ensures the availability of well-trained investigators who reflect our nation's diversity and who have specialized knowledge, methodological expertise, and creativity. NIH's research training grant portfolio covers all the career stages that are key to the recruitment, training, and retention of productive medical researchers.

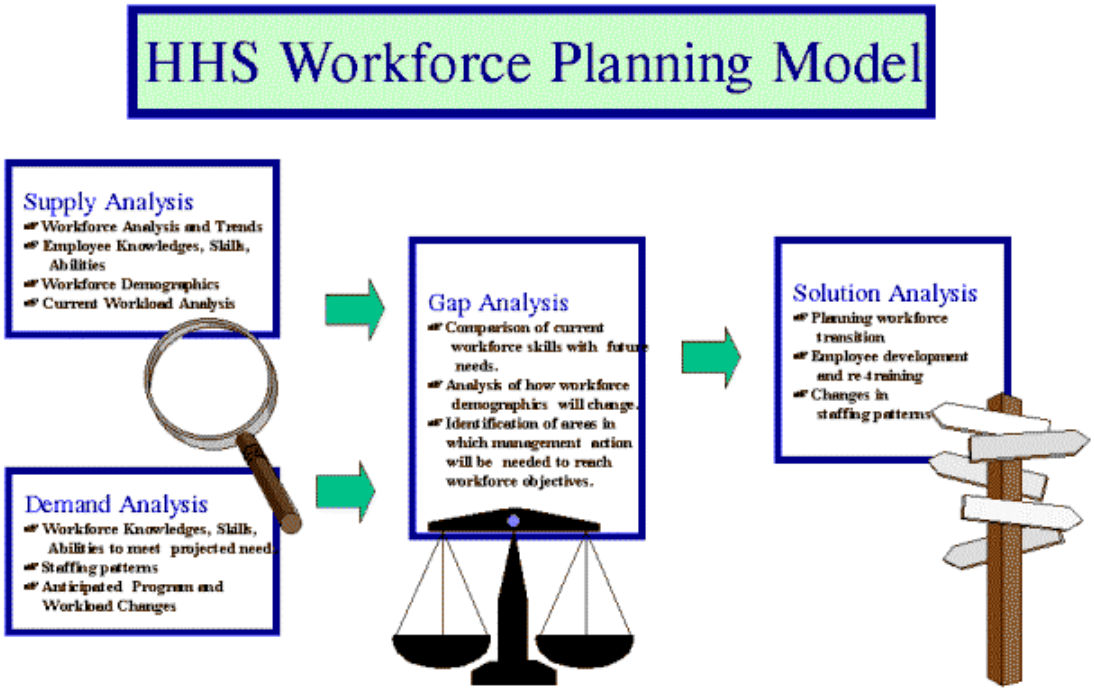
One of the goals of research training is to teach pre- and post-doctoral students how to conduct innovative, high-quality science, including how to identify problems, develop hypotheses, design experiments, choose model systems, and see connections among different fields that allow a scientist to make quantum leaps in understanding a problem. Mentors are a critical training resource, serving as role models and providing guidance that ensures trainees develop into successful investigators.

6. Sustaining the Nation's Research Facilities

NIH must continually support the development, maintenance, and renewal of physical resources that are vital to the rapid pace of scientific discovery. The past achievements of medical research have required access to state-of-the-art laboratories. Up-to-date and safe research facilities are essential to assuring continued progress in the medical sciences. To support intramural research, NIH constructs new facilities and renovates existing ones to meet the ever-changing needs of biomedical research. NIH also provides support to extramural grantees through research facilities construction grants designed to assist in the construction and modernization of non-federal research

C. Workforce Planning Approach

1. Planning Model



In formulating this workforce plan, NIH was guided by the HHS policy document, "Building Successful Organizations, Workforce Planning in HHS." The HHS workforce planning model proposed in this issuance prescribes a four step planning process.

a) Supply Analysis

Supply analysis focuses on identifying organizational competencies, analyzing staff demographics, and identifying employment trends. Competency analysis provides baseline data on the existing organization and present staff. Trend analysis provides both descriptive and forecasting models describing how turnover will affect the workforce in the absence of management action. Trend analysis is essential to the solution analysis phase.

b) Demand / Gap Analysis

Although demand and gap analysis are two separate steps in the planning model, they are very closely related. In the following plan, we have combined these steps in order to eliminate redundancy and improve the logical flow.

Demand Analysis

Demand analysis deals with measures of future activities and workloads, and describing the competency set needed by the workforce of the future. Demand analysis must take into account not only workforce changes driven by changing work but also workforce changes driven by changing workload and changing work processes. Technology will continue to have an impact on how work is performed and must be considered in the demand analysis process.

Gap Analysis

Gap analysis is the process of comparing information from the supply analysis and demand analysis to identify the differences " the "gaps" " between the current organizational competencies and the competency set needed in the future workforce. The comparison requires the competency sets developed in the supply analysis and demand analysis phases to be comparable " not independently developed. Gap analysis identifies situations in which the number of personnel or competencies in the current workforce will not meet future needs (demand exceeds supply) and situations in which current workforce personnel or competencies exceed the needs of the future (supply exceeds demand).

c) Solution Analysis

Solution analysis is the process of developing strategies for closing gaps in competencies and reducing surplus competencies. A variety of strategies are available in solution analysis including planned recruiting, training, re-training, and placing employees. Solution analysis must take into account employment trends which may work either in the favor of or counter to the direction of planned workforce change.

2. Additional Context

In line with the HHS Workforce Planning Model, the NIH plan:

Reflects a corporate perspective, and is not merely compilation of information from the ICs;

Addresses the issue of critical workforce skills, and informs the reader as to which will be needed in the future, how these skill requirements will change over time, and the skill gaps the NIH anticipates;

Reflects specific recruitment, training and development, retention and succession planning strategies to remediate these anticipated gaps.

Provides strategies that include specific action steps and timelines, including the use of recruitment and retention incentives to fill critical mission needs, redeployment of staff from lower to higher priority areas, development of succession plans and support for HHS initiatives such as the Emerging Leaders, the HHS University, and the SES Candidate Development Program.

In May 2002, the Office of the Secretary finalized a recruitment and retention strategy (Appendix 2). The strategy was based on an extensive study of the Department workforce including data about the NIH staff. Although the scope of this study was the entire Department, many of its findings are directly applicable to the NIH. In the following discussion, we rely heavily on the data analysis and conclusions of this study.

II. Workforce Supply Analysis

A. Core Occupational Groups

NIH considers the following occupational groups to represent its core workforce. These groupings were chosen for several reasons. They represent most of the NIH workforce. More than 90% of the NIH workforce falls into these categories. They perform work that is most directly related to the achievement of the NIH mission.

Research Contracts and Grants. Health Scientist GS-601, Grants Specialist GS-1101, Contract Specialist GS-1102.

Research Scientist. Biologist GS-401, Chemist GS-1320, Microbiologist GS-403, Psychologist GS-180, Pharmacologist GS-405, Mathematical Statistician GS-1529, Veterinarian GS-701, Computer Scientist GS-1550, Physiologist GS-413, Physicist GS-1320, Geneticist GS-440, General Engineering GS-801, Computer Engineering GS-854, Electronics Engineering GS-855, Biomedical Engineering GS-858, Chemical Engineering GS-893.

Physician. Medical Officer GS-602.

Nursing. Nurse GS-610, Practical Nurse GS-620, Nursing Assistant GS-621, Health Aid and Technician GS-640.

Research Technical Support. Biological Technician GS-404, Medical Technologist GS-644, Diagnostic Radiological Technologist GS-647, Medical Machine Technician GS-649, Nuclear Medicine Technician GS-642.

Information Technology, IT Specialist GS-2210 (formerly Computer Specialist GS-334), Computer Clerk And Assistant GS-335, Computer Operations GS-332.

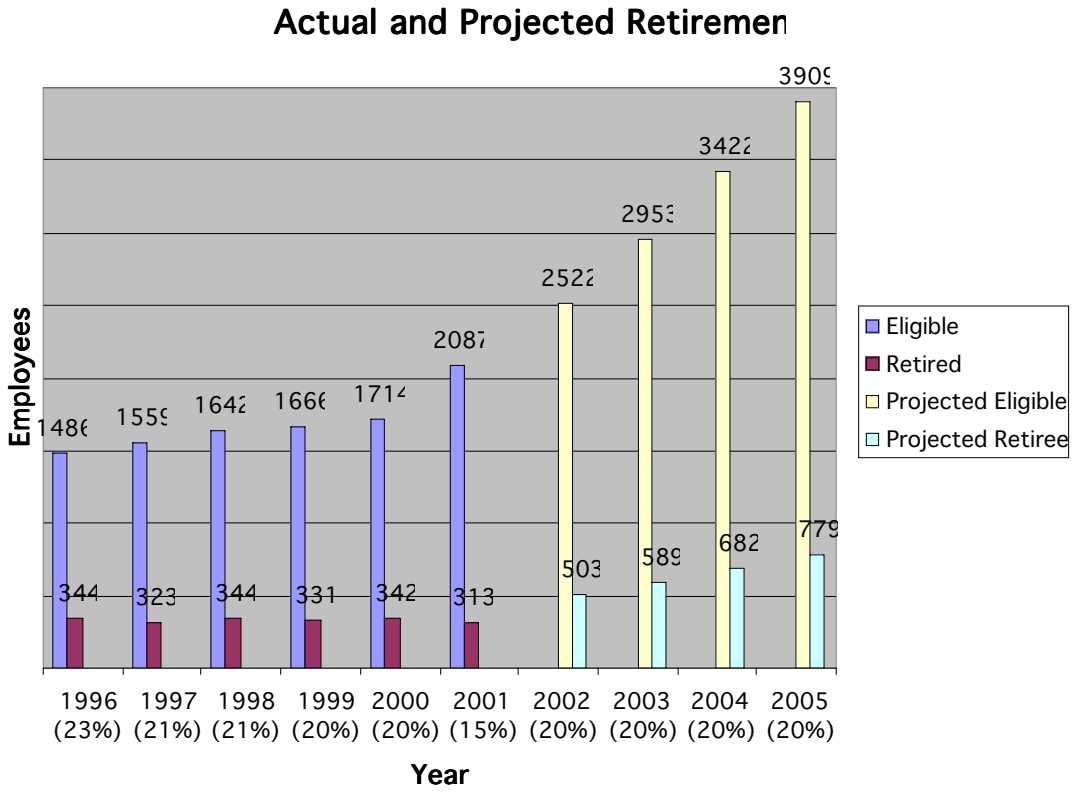
Science Information. Technical Information Services GS-1412, Librarian GS-1410, Library Technician GS-1411, Technical Writing And Editing GS-1083, Writing And Editing GS-1082, Communications Management GS-391, Visual Information GS-1084, General Arts and Information GS-1001, Editorial Assistance GS-1087, Printing Management GS-1654, Audio-Visual Production GS-1071, Exhibits Specialist GS-1010.

Administrative Support. General Administration GS-301, Management Analysis GS-343, Administrative Officer GS-341, Personnel Management GS-201, Purchasing GS-1105, Budget Analysis GS-560, Public Affairs GS-1035, Accounting GS-510, Equal Employment Opportunity GS-260, Financial Administration and Program GS-501, Program Management GS-340.

B. Workforce Analysis and Trends

1. Retirement

Like the rest of the Department, NIH faces an impending loss of expertise as the cadre of staff who will reach retirement age over the next few years begin to retire. Retirement projections for all of NIH are reflected in the following chart.

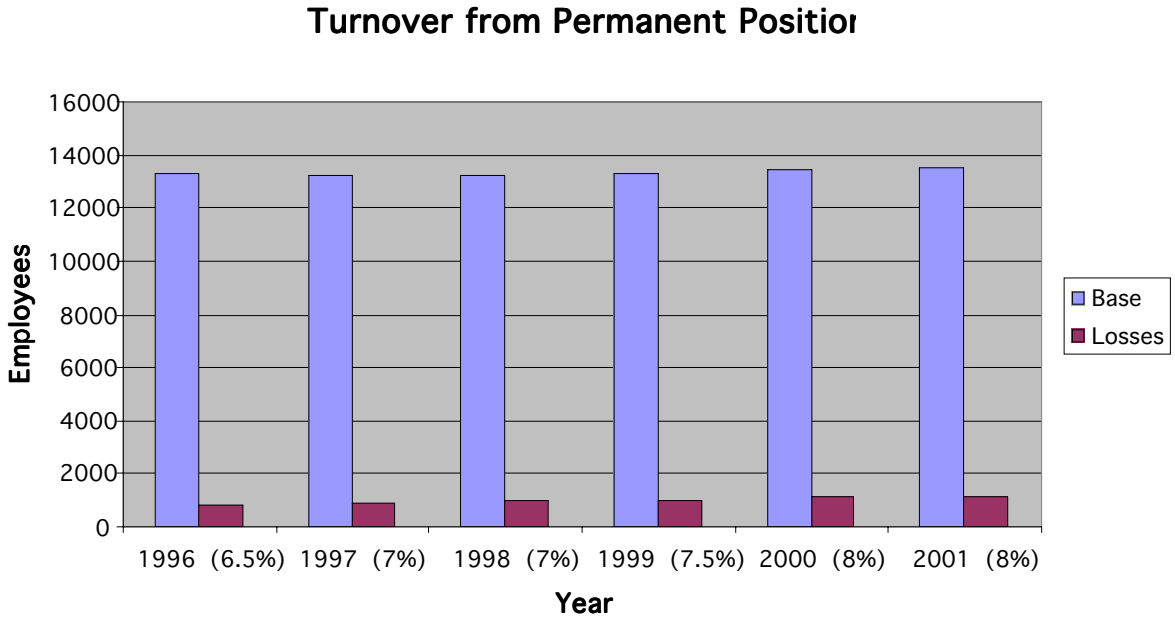


Within the Research Scientist group, chemists are the only group projected to retire at a higher rate than their colleagues. Over 24% of NIH chemists are eligible to retire today and the percentage will increase proportionally over the next several years. By the end of FY 2006, nearly half of this population will be eligible to retire.

Retirement projections for each core occupational group are being computed and will be provided as an appendix to this plan.

2. Turnover

The following chart shows the rate of turnover from permanent positions that has been characteristic of the NIH workforce for a number of years.

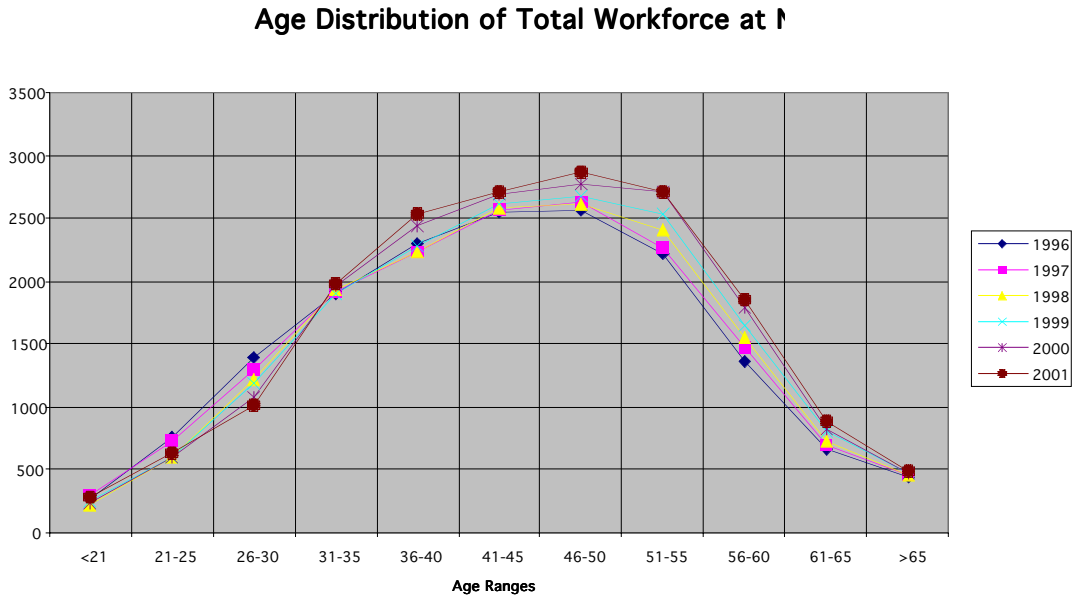


At the NIH level, the rate of turnover is low and consistent. Turnover rates for each core occupational group are being computed and will be provided as an appendix to this plan.

C. Workforce Demographics

1. Age of Workforce

The NIH workforce is aging. Changes in the age distribution of the NIH workforce since 1996 are indicated in the chart below:



Age distributions for each core occupational group are being computed and will be provided as an appendix to this plan.

2. Workforce Diversity

NIH's overall percentage of minority employment is close to or better than the nationwide percentage of minorities aged 18 years or older.

In looking at specific minority categories, NIH is meeting the nationwide percentage in most areas. The exceptions are:

Hispanic. Representation is substantially below average in every core occupational group.

Native American. NIH is below average for Native Americans as a whole, most significantly in the Research Scientist core occupational group.

Asian/Pacific Islander. Representation falls short in two core occupational groups -- Nursing and Administrative Support.

African American. Representation is below average in the Nursing, Physician, Research Scientist and Research Contracts and Grants core occupational groups.

D. Employee Knowledges, Skills and Abilities

1. Training and Career Development Opportunities

Training the next generation of biomedical researchers is an integral component of the NIH mission. So, it is not surprising that NIH provides its own staff with a rich array of opportunities for furthering their education and career development. Some examples are as follows.

Foundation for Advanced Education in the Sciences (FAES) Graduate School

The NIH cooperates with the FAES to provide a curriculum of scientific course offerings to the NIH workforce. The beginnings of FAES can be traced back to the early 1950's, when a Graduate Evening Program was formed at the National Institutes of Health (NIH) to permit members of the science and medical community to supplement laboratory training with advanced formal education. By 1959, FAES was incorporated as a non-profit organization with a mission "to foster and encourage scientific research and education, and to facilitate communication among scientists, by whatever means may be practical."

Each year approximately 3,000 individuals participate in the courses offered by the FAES Graduate School. Courses are offered at both graduate and undergraduate levels. The majority of the School's faculty is made up of NIH staff, making their specialized knowledge available to a wider audience. Although the primary recipients of the School's programs have always been members of the NIH scientific staff at all levels, courses are also open to other Federal employees and the general public.

There are presently almost 184 courses at the school, each certified by the Maryland Higher Education Commission and accepted for credit at

most universities. The majority of the classes are in the biomedical field. However, there is strong representation in the physical and behavioral sciences, and in English and foreign language studies, providing valuable opportunities for:

- College advanced placement for superior high school juniors and seniors
- Focused refresher and skill update training
- Medical specialty board preparation
- Continuing medical and biomedical education
- Laboratory skill enhancement
- Language preparation for foreign travel

Courses of study at FAES Graduate School include:

- Biochemistry and Biophysics
- Biology and Genetics
- Biotechnology (BIO-TRAC)
- Computer Sciences
- Chemistry and Physics
- General Studies
- Imaging Sciences
- Immunology and Microbiology
- Languages
- Medicine and Physiology
- Medical Subspecialty Review Courses
- Pharmacology and Toxicology
- Psychiatry and Psychology
- Statistics

Clinical Research Training Program

In order to assure the highest quality of research in its intramural research program (IRP), the NIH recently developed an extensive web-based clinical research training curriculum. The course addresses one of the essential standards recently approved by the NIH for performing clinical research in the IRP. All clinical principal investigators with a

protocol approved through the NIH Clinical Center are required to take the course and successfully complete a final exam.

The course is available on the web via:

www.nihtraining.com/cc/crt/indexvideo.html

Topics are presented by leading experts and include:

- Ethical Issues in Human Subjects Research
- Roles and Responsibilities of the Investigator
- Roles and Responsibilities of the Institution
- Regulatory Issues
- Clinical Investigators and the Mass Media

Information Technology Training

The NIH computer training program provided by the Center for Information Technology offers a wide variety of courses that enable users to make efficient and effective use of computing, networking, and information systems in their work at NIH. The training program is open to NIH employees and to all users of CIT computing facilities..

The program includes classroom courses, seminars, and self-study courses. Interactive class attendance via video conferencing can be arranged for students in off site locations. A listing of current offerings is available at http://training.cit.nih.gov/.

Training Center

NIH provides a broad selection of administrative training courses through its corporate training center. Courses are offered in both the traditional classroom format and online. Current course offerings are available in the following areas:

- Administrative Skills
- Administrative Systems
- Career Transition

- College Courses
- Communication Skills
- Computer Applications and Concepts
- Financial and Procurement Management
- Human Resource Management
- Management, Supervisory, and Professional Development
- IMPAC II Courses
- HHS DL\net Portal to Online Learning

In addition, the training center offers the following career development opportunities:

Career Development Programs
- NIH STRIDE Program
- Management Internship Programs (NIH coordination of the Emerging Leaders Program, NIH Management Cadre, NIH Management Intern Program, and Presidential Management Intern Program)

Certificate Programs
- Knowledge Associate Certificate Program
- Project Management Certification Program
- Career Studies Certification Program

Women in Science Workshops
- Communication and Negotiation for Women in Science
- Giving Dynamic Presentations for Women in Science
- Successful Mentoring for Women in Science

The training center also offers customized training and development solutions including:

- Customized Training
- Customized Technology Solutions
- Performance Consulting
- Retreat, Seminar, & Meeting Planning
- Executive Coaching

Additional information about the training center and its programs is available at: http://learningsource.od.nih.gov/.

2. Skills Inventory

NIH is performing targeted skills assessments for employees affected by all forms of restructuring, including outsourcing activities. As affected employees are being identified, NIH will assess their skills, identify potential career targets, and provide re-training to ensure successful redeployment. A more in-depth discussion of the NIH plan to address this issue can be found in Appendix 4 - Draft NIH Transition Plan.

III. Workforce Demand / Gap Analysis

A. Anticipated Program and Workload Changes

1. Research Agenda

The primary driver of NIH workforce needs is the NIH scientific research agenda. The research agenda for FY 2003 includes the following broad areas of focus.

a) Bioterrorism

The events of September 11, 2001, and the subsequent intentional release of anthrax spores are having a substantial effect on the NIH and the research it supports. It is clear that the NIH has an important role in both conducting research on the agents of bioterrorism and in ensuring that there is up-to-date and accurate information on therapeutic options and other interventions to guide the responses to terrorist attacks.

In consultation with the Federal Office of Homeland Security and the HHS Office of Public Health Preparedness, the NIH has developed a FY 2003 budget request that includes a total of $1,748 million for bioterrorism-related research and infrastructure, an increase of $1,473 million over FY 2002. Of this amount NIH estimates that it will fund $977 million for bioterrorism research activities, to continue existing bioterrorism-related programs as well as initiate new ones.

The initial focus of this research effort is on the agents identified in the Centers for Disease Control and Prevention threat list. The goals of this markedly expanded research effort are to develop the countermeasures

that will be needed to respond to and control the intentional or unintentional release of agents of bioterrorism. This program is designed to maximize the efforts of industry, academia, and federal researchers to accelerate the development of new and safer vaccines, therapeutic agents, and improved diagnostic tests.

The plan consists of four, broad interconnected efforts:

Expand basic research on the physiology and genetics of potential bioterrorism agents, on immune system function and on response to each potential agent, and the pathogenesis of each disease.

Accelerate discovery and development of the next generation of vaccines, therapeutic agents, and diagnostic tests using knowledge from basic research.

Expand clinical research on newly discovered and developed products to test for safety and effectiveness.

Expand research infrastructure to enable biomedical research efforts on pathogenic microbes, including potential bioterrorism agents.

b) Cancer

With focused efforts and increased resources, NIH will build on past successes and technological breakthroughs to stimulate progress in addressing some of our most difficult questions about cancer. The FY 2003 President's budget request will allow the NIH in total to support an estimated $5.5 billion in cancer research. Our increased investments in all areas of cancer research will accelerate the pace of cancer research and improve our ability to find better ways to care for those whose lives are touched by cancer.

Support will be provided for large-scale studies on critical cancer control, prevention, and screening questions. For example, the NIH will conduct the largest-ever prevention study to determine if vitamin E and selenium can protect against prostate cancer. For this trial, NIH will be working in partnership with the Southwest Oncology Group, that records participants

from over 400 sites in the United States, Puerto Rico and Canada, one of several cancer cooperative groups sponsored by the agency.

The NIH and another cooperative group, the American College of Radiology Imaging Network, will launch the first large, multicenter study to compare digital mammography to standard mammography for the detection of breast cancer. Digital mammography technology provides higher resolution images than standard mammography, and investigators want to determine if it can detect breast cancer more accurately. A total of 19 institutions in the United States and Canada will take part in the study.

Furthermore, investigators who are part of an NIH Cohort Consortium will be working to uncover potential interactions of genetics and environmental exposure by combining data from prospective cohort studies involving 7,490 cases of breast cancer and 7,130 cases of prostate cancer. Interactions between established risk factors and a set of genetic variants associated with these cancers will be studied. The collaborative effort will serve as a model for future efforts that can take full advantage of investments in large population studies and increase our understanding of what is needed to better control, prevent, and treat cancer.

As a result of budget increases, the Institutes and Centers (ICs) at the NIH have many new research initiatives underway, all of which will be continued in FY 2003 and beyond. The following three areas also represent particularly outstanding scientific opportunities that have the promise to yield enormous benefits in the future in the form of new knowledge and treatment and prevention strategies. The prospects for improvements in health and quality of life from medical research provide hope for a healthy future.

c) Diabetes

Diabetes is a chronic disease and can result in serious complications and premature death if not well-managed by patient and caregiver. Recent data show that over the past decade and even over the past year, there has been a dramatic increase in obesity and type 2 diabetes in the U.S. across all age groups, including adolescents, and in all racial/ethnic

groups, with Hispanic-American, African-American, and Native American groups particularly severely affected.

A recently completed Diabetes Prevention Program trial provided proof of principle that modest lifestyle changes can prevent type 2 diabetes in high-risk people with impaired glucose tolerance. The impetus now is to develop more effective methods to identify individuals with impaired glucose tolerance and to provide intervention. Cost effective approaches directed at providers, high-risk individuals, and communities to support achieving these lifestyle changes must be developed and validated. Research is needed to: 1) understand health care providers' knowledge, attitudes, and skills related to diabetes prevention and how providers can be encouraged and enabled to provide effective lifestyle intervention; 2) understand an individual's knowledge about personal risk and the importance of prevention and how they can be motivated and empowered to achieve lifestyle change; and 3) understand and alter social, environmental, and community factors that influence lifestyle and choices. A trans-NIH Request for Applications focused on research addressing these issues is under development for FY 2003.

With respect to type 1 diabetes, NIH scientists are continuing research on islet transplantation in humans, and preliminary studies appear promising. Other research will include, for example, an oral insulin study of the Diabetes Prevention Trial for Type 1 Diabetes, for which recruitment has begun. Investigators have also convened meetings to plan clinical studies on type 1 diabetes as part of the Diabetes TrialNet. The TrialNet will include clinical centers, recruitment networks, and a coordinating center. It will provide the research infrastructure needed to foster the future design and execution of pilot studies and expanded clinical research. The TrialNet will permit more rapid clinical testing of novel approaches to treatment and prevention.

The NIH plans to investigate ways in which interventions that have already been demonstrated to be beneficial by laboratory or clinical investigations can be extended or adapted to larger populations to improve health care delivery and diabetes self-management and to promote healthy lifestyles to reduce the risk of diabetes and obesity. The NIH will also support studies on an important group of proteins called

orphan receptors. To advance research on diabetes and related areas of endocrinology and metabolism, the NIH will strive to expand diabetes research centers to bring together clinical and basic science investigators from relevant disciplines.

d) Minority Health and Health Disparities

In support of Secretary Thompson's commitment to eliminating minority health inequities, efforts to address disparities in health among minorities and other disadvantaged populations compared to the majority, remain a top priority of the NIH. There are complex factors that underlie disparities in health status — factors that converge and cause differences in disease progression and in health outcomes. While the diversity of the American population is one of the Nation's greatest assets, one of its greatest challenges is reducing the profound disparity in health status of America's racial and ethnic minorities and rural populations, including Appalachian residents, and other similar groups, compared to the population as a whole.

Infrastructure support is an essential part of the framework for the conduct of high quality research and a means of facilitating the participation of minority institutions in such research. The Center of Excellence Endowment Program, Institutional Development Award (IdeA) Program, Biomedical Research Infrastructure Network (BRIN) and the Resource Centers for Minority Aging Research are a examples of research infrastructure support for minority health and health disparities fostered by the NIH.

Plans are also underway to develop Partnership Programs of Excellence in Minority Cardiovascular Health Research. Important aspects of the programs will include community involvement in the research, outreach strategies for patient recruitment and retention, and development of new investigators interested in reducing cardiovascular health disparities. The NIH will also continue research-based health education activities on diabetic retinopathy in the Mexican-American population who are known to have a high rate of diabetes along with more severe hyperglycemia, which indicates poor glucose control.

Other efforts include research on drug abuse and addiction, including efforts to reduce the impact of HIV/AIDS and other disease consequences of drug abuse in minority populations; identifying underlying mechanisms of gender and ethnic differences in the etiology of alcoholism and alcohol-related tissue damage, which is a prerequisite for developing effective treatments for alcoholism and alcohol-induced organ damage in women and ethnic minorities; research to prevent or reduce oral health disparities; an expanded program of Specialized Neuroscience Research Programs; projects involving African Americans affected with diabetes and hereditary prostate cancer; and research on HIV treatment and prevention research, hepatitis C virus, asthma, and autoimmunity — conditions that disproportionately affect minority communities. The NIH and its national, State, and local partners will be working to better understand and address the high cervical cancer mortality rate that exists in much of rural America.

e) Parkinson's Disease

Genetics, cell biology, and pharmacology are all contributing to new advances in Parkinson's disease upon which the NIH is building its growing effort to understand, prevent and treat this devastating disease. Several genes and their expressed proteins associated with Parkinson's disease have been identified, and efforts are now focused on understanding their role in the disease process.

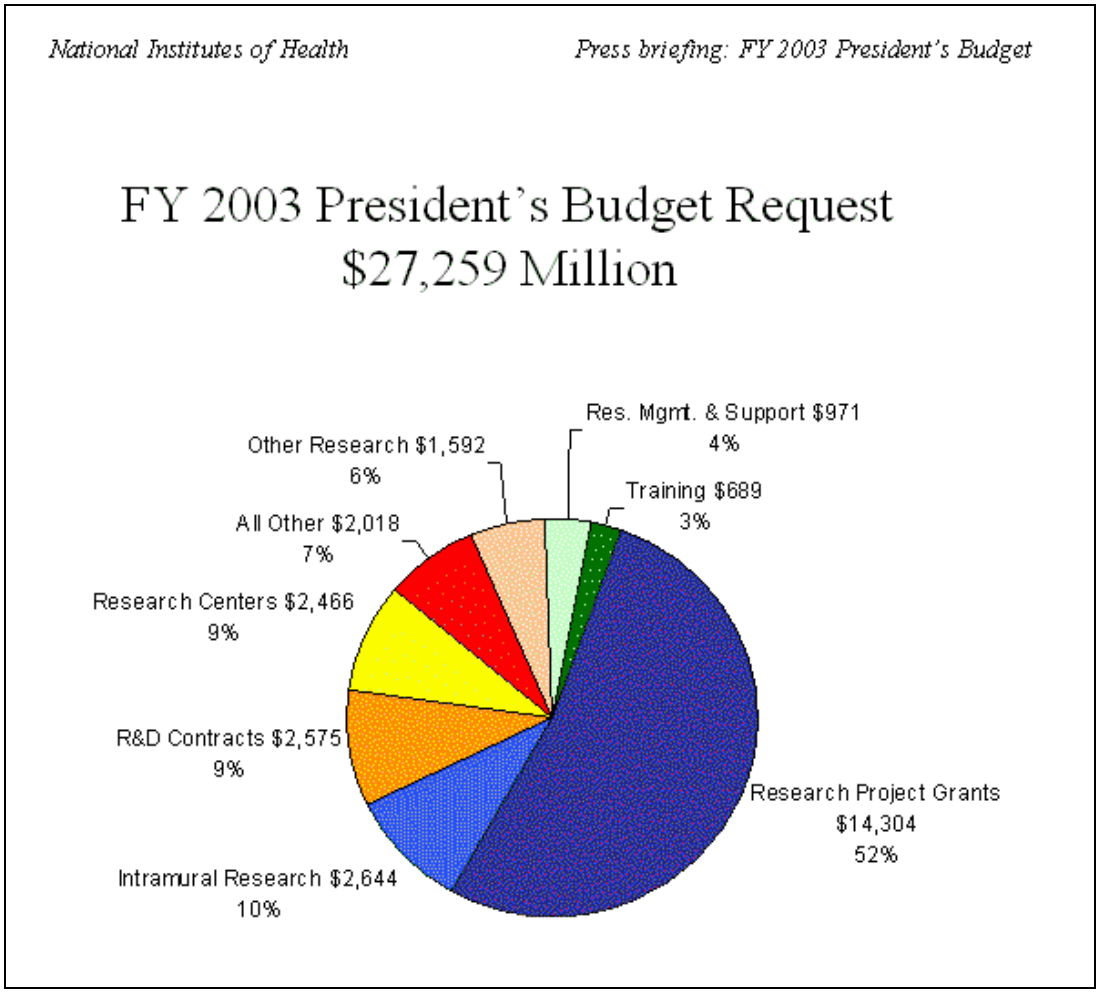
Nerve cells that produce the neurotransmitter dopamine die in Parkinson's disease. Current treatment is based on replenishing the dwindling supplies of dopamine in the brain. However, this treatment does not slow the underlying death of nerve cells and ultimately fails as the disease progresses. To address this underlying problem, efforts are now underway to expand the work at more than 40 clinical centers to test neuroprotectants — drugs that actually slow or stop the progression of the disease.

Many of these efforts and the ones planned for FY 2003 emerged at a January 2000 workshop, at which intramural, extramural, and industry scientists, representatives from several Parkinson's disease advocacy groups, and ethicists held intensive discussions which formed the basis of the "NIH Parkinson's Disease Research Agenda." The Agenda

encompasses research from basic studies to understand the normal brain functions disrupted by this disease through clinical studies of therapeutic strategies, including drugs, cell replacement, gene manipulations, and surgery

NIH is aggressively undertaking various activities to carry out this Research Agenda. Grant solicitations include: the role of the environment in Parkinson's disease and career development awards in the role of the environment in Parkinson's disease; consortium on deep brain stimulation for the treatment of Parkinson's disease; function of synaptic proteins in synaptic loss and neurodegeneration; role of parkin and related proteins in Parkinson's disease; mitochondrial function in neurodegeneration; and mechanisms of action of deep brain stimulation, among others.

2. Funding Priorities



FY 2003 will be the final year in a five-year period during which the NIH budget was doubled. There will be resource increases in every area of the NIH mission. These increases have allowed the NIH to build a broad portfolio of research that provides the foundation for incremental advances and medical breakthroughs. This investment includes funding for basic and clinical research – both important to understanding and solving problems related to specific diseases and public health problems such as cancer and bioterrorism. Funding for these projects includes investigator training, the cost of equipment, supplies, and services such as facility maintenance and information management.

B. Critical Workforce Skills

The workforce skills critical to the NIH derive from the research agenda and funding priorities described above.

Scientists and Support Staff

In order to accomplish all aspects of its expanding research agenda, the NIH needs to enlarge its cadre of highly skilled, scientific and program support staff. Both scientific and grants management duties have increased in direct relation to the growth in both the NIH research agenda and budget as mandated by Congress. This results in increased scientific staff needs to conduct and administer research and increased staff support needs to ensure proper oversight of grants and to complete administrative tasks that are essential to the advancement of major research initiatives.

Specifically, NIH needs individuals with M.D, Ph.D., or similar degrees in biomedical and behavioral research and in related areas critical to these fields, such as physics, biophysics, computational biology, chemistry, engineering, statistics, computer sciences and mathematics.

Increasing Need for Clinical Expertise

Within the overall scientific category, NIH also needs to attract additional clinicians to perform the research necessary to translate the new

knowledge gained through basic research activities like mapping the human genome into new cures, therapies and preventive measures.

Multi-Disciplinary Science and Collaborative Expertise

Increasingly, leading edge biomedical research is conducted not by single investigators, but by large multi-disciplinary teams of collaborating researchers. This imposes new requirements on both those who conduct research in the NIH intramural program and those who oversee research conducted by other organizations funded through the NIH extramural program. NIH recruitment and internal staff development efforts have traditionally focused on recruiting and developing staff with specialized scientific expertise. NIH must broaden its recruitment and training efforts to acquire and develop staff with the multidisciplinary backgrounds and collaborative skills required by 21st century scientific research.

Research Facilities

Finally, NIH requires the services of engineers, architects, and highly trained workers to maintain our research laboratories and clinical care facilities on the main campus in Bethesda and surrounding areas, in North Carolina and in other locations around the country. We need a "non-scientific" workforce that is flexible, a change agent that is willing to develop new skills and take on new assignments to improve the efficiency of the service. Currently these needs are met by NIH staff. As the facilities function is consolidated, responsibility for providing these critical facilities management services may shift to a centralized provider. However, the skills required remain the same regardless of how they are provided.

C. Workforce Knowledges, Skills and Abilities to Meet Projected Needs

This section describes the gaps the NIH has identified in its ability to meet projected workforce needs. The plan addresses the actions to address these gaps in Section IV.

1. Multidisciplinary Research Skills

As mentioned above, biomedical research is being conducted today by large, multidisciplinary teams working collaboratively rather than by single investigators working in relative isolation. The investigators and science administrators who execute NIH research agenda will need to be broadly prepared in multiple disciplines and will need to have outstanding collaborative skills.

NIH recruitment efforts will need to be refocused on acquiring these critical new skills. Staff development efforts will need to be reexamined to assure that NIH is developing the current scientific workforce along these lines. NIH already promotes continuing science education for its staff in a multitude of ways. Research training is an explicit component of the NIH mission, and that deep commitment is reflected in the many educational opportunities that NIH offers its scientific staff. However, the need for learning is ongoing. These educational initiatives must continue and expand to keep up with the rapid pace of scientific discovery and the enormous requirements of translational research that face the NIH over the next decade.

2. Leadership

NIH is a world-class biomedical research organization and achieved that status through the outstanding leadership of its senior staff. Even in normal times, there is a compelling need to develop new leadership to offset turnover. The combination of a greatly expanded research agenda and the demographics now driving retirements from the NIH leadership cadre make it imperative that NIH increase its commitment to leadership development.

3. Mentoring Skills

One answer to the “brain drain” problem is aggressive implementation of mentoring programs in both the scientific and administrative components of the NIH. However, successful mentoring requires a specific set of skills. To be fully successful in promoting mentoring, NIH needs to take a systematic approach to training a cadre of potential mentors. NIH has taken several steps in this area. Recently, NIH sponsored a formal training program to prepare mentors of interns in the various NIH internship programs. Both the NIH Training Center and the NIH Work Life

Center are adding courses and other resources to support mentoring. The NIH Office of Intramural Research is implementing a formal program of mentoring for scientific staff in various stages of career progression.

4. IT Skills

Information technology continues to be a key enabler of NIH research activities. NIH provides one of the leading information technology training programs in the government. However, information technology and its uses evolve so quickly that NIH needs to continue the current level of commitment and consider expanding it. NIH offers scientific and administrative computing courses through the Center for Information Technology, the NIH Training Center (including a host of on-line courses offered through the HHS DL/Net Learning Portal and the Fastrac on-line system).

D. Restructuring

NIH is engaged in a number of restructuring activities, each of which is addressed below. These descriptions lay out the restructuring areas, while NIH responses to these issues are addressed in Section IV. As discussed elsewhere in this plan, these changes require the NIH to plan for the re-training, redeployment or outplacement of staff affected by the changes.

1. Administrative Consolidation

HHS has made a commitment to reduce the number administrative positions Department-wide by 700 FTEs by the end of FY 2003. Numeric requirements have not been imposed at the OPDIV level. However, if the allocation of absorbing these administrative staff reductions is based on FTE levels, NIH should expect to reduce it administrative staffing levels by about 190 FTEs by the end of FY 2003.

As reported in other documents, the NIH is ready to launch its centralized HR office on October 1, 2002, and continues to work on the HHS team designing the overall consolidation of the HR function in HHS. The NIH Director of Equal Opportunity is active in an HHS group studying potential consolidation of equal employment opportunity functions, and we are awaiting OS decisions on this issue. The NIH Chief Information Officer is

actively participating in an HHS working group on IT consolidation, which is preparing a plan for the Assistant Secretary for Budget, Technology and Finance. IT consolidation at the NIH is an area under review by the NIH Director. Tentative decisions, to be discussed with ASBTF staff, should be made in early fall. The EEO informal complaints process, decentralized to 13 Institutes and Centers and handled centrally by the Office of Equal Employment Opportunity for the rest of the NIH, will be centralized early in Fiscal Year 2003. The agency has provided OS with information about staff associated with facilities management, legislative affairs, and public affairs to assist in OS plans to centralize those functions.

2. De-Layering

In support of the President's Management Agenda mandate regarding a flatter, more citizen-centric government, the Department has directed NIH to reconfigure its organizational structure so that there are no more than 4 layers of management. In evaluating how best to accomplish this outcome while ensuring that the complex and critical programs of the NIH receive the appropriate level of stewardship, we considered how some other HHS Operating Divisions have restructured, reviewed all of the NIH organizations for structures that exceed four levels, and have developed a specific plan and time frame to meet this requirement.

E. Competitive Sourcing

The President's Management Agenda calls for action to assure that government work is performed by the most efficient sources. To achieve a "green light" in this item, an agency must complete cost-comparisons between the current cost (performed by government employees) and costs if outsourced for 50 percent of the agency's "commercial" positions by the end of FY 2005. At the NIH, there are nearly 9,300 commercial positions; cost-comparisons must be completed on 5 percent of these positions by the end of 2002; on an additional 10 percent in 2003; 10-15 percent in 2004; and the remainder in 2005 (20-25 percent). To ensure that the NIH approach was the most effective, we adopted an "expert choice" plan to evaluate all of the commercial positions. Each function was ranked based on three dimensions, and then an overall ordinal ranking was reached. This ranking then was reviewed by a steering committee that represents a wide spectrum of NIH

organizations, and finalized. The final list, provided to the Office of the Secretary, includes functions/positions that will be evaluated in FY 2003 and many of the functions/positions to be evaluated in FY 2004. This list is included as Appendix 5.

F. Information Technology Impacts

1. NBRSS

Implementation of the NIH Business and Research Support System (NBRSS) beginning in late 2002 is expected to have workforce impacts. Specifically, the system will incrementally eliminate some functions, create new opportunities, move functions from ICs to central units, and require higher-level analytical skills from some employees.

2. E-Grants

As NIH moves to implement a fully electronic grants process, there will be a growing effect on the number and mix of grants management staff (specialists and assistants) needed.

3. CRIS

The Clinical Research Information System (CRIS) will at a minimum require new skills for staff who use the system. As the system is implemented, there will also be an impact on the numbers and types of staff required to manage medical records.

IV. Solutions

A. Planning Workforce Transition

1. Managing Administrative Consolidation

a) HR Office Consolidation

The NIH is ready to implement its centralized HR office on October 1, 2002, and continues to work on the HHS team designing the overall consolidation of the HR function in HHS. As part of this process, the NIH:

- Consolidated 11 separate Servicing Personnel Offices to a single SPO.
- Conducted dozens of focus groups and consulted with NIH staff to develop a responsive model that has the acceptance of managers and supervisors
- Benchmarked both Federal and private sector institutions' HR functions,
- Developed an organizational model
- Presented our process and model to other HHS agencies
- Reassigned staff the new organization
- Identified immediate savings of approximately 10% of staff resources (432 to 390
- Collapsed from 27 operating personnel offices to 1
- Consolidated HR operations functions by having only 9 branches,
- In addition to the staff reduction mentioned above, reassigned 65 staff from IC operations to provide centralized services to all of NIH
- Centralized all employee and labor relations functions from the 27 ICs
- Centralized approximately 20 Delegated Examining Units to 1
- Established a centralized corporate recruitment function that recruits centrally for common positions
- Established a new HR management review and controls organization designed to surface quality control issues
- Established a central HR information technology function to look at efficiencies that might be gained through automation

A key part of the HR organizational model is the establishment of an entirely new function within NIH HR. The Human Resources Performance Assessment Staff is charged with assessment and evaluation of the effectiveness of NIH HR functions. In order to ensure that this staff conducts evaluations of areas of concern to OS, NIH will assure that this staff meets periodically to discuss functions that OS considers important for prompt evaluation. In addition, we will share the results of the evaluations performed by the staff and the corrective actions that NIH will require.

The NIH HR staff has already initiated the development of a career-long orientation and training program for HR staff at all levels. The intent of

the orientation component is to develop an understanding of NIH and HHS programs, priorities and goals and to foster an environment of corporate-level responsibility. In addition, HR staff will be required to complete specific professional development and technical training before advancing to the full performance level.

b) Other Administrative Consolidations

The NIH Director is evaluating how best to meet the goal of administrative consolidation in a balanced fashion. He has appointed a group of senior managers to prepare recommendations, which will be discussed in the next month. We expect that tentative decisions will be made in the early fall and discussed with OS at that time.

c) Reductions in Administrative Staff

NIH will meet its share of the HHS goal of reducing administrative staff by the end of FY 2003. The agency will achieve this outcome by imposing hiring controls on administrative positions, restructuring of administrative functions that will result in FTE savings (e.g., an immediate savings of 10 percent of the FTEs devoted to human resources upon centralization effective October 1, 2002), and by competing some administrative functions under A-76[1]. We have recently reviewed our hiring needs in the administrative area, and have reduced them accordingly to incorporate this reduction. While we now plan to hire approximately 800 non-IT administrative staff in the next two fiscal years combined, and 200 IT staff, this number was developed after considering the administrative reductions, impact of consolidations, and the potential impact of A-76, and is substantially reduced from previous estimates.

2. Succession Planning

Senior leadership staff in every critical program area of the NIH are becoming eligible for retirement in larger numbers each year. The demographics are such that this trend is clearly going to accelerate over the next several years. New systems and processes for succession

[1] NIH recently submitted its list of functions to be studied for potential outsourcing in 2003 and a partial list of functions for 2004 (1,620 total FTE). Of these, slightly over 300 are in administrative functions, and about 100 are in information technology. NIH will control hiring in these functions pending the outcome of the cost comparison studies.

planning must be identified and implemented to ensure continuity and excellence in achieving the NIH mission.

Management views about succession planning need to change. Planning for succession must be ingrained in all employees from day one. NIH top executives should focus on early identification and grooming of individuals with leadership potential throughout the organization. In short, succession planning needs to become a pervasive element of the NIH management culture.

To achieve this, NIH will establish a succession planning and leadership development program. This program will be overseen by a high level governing committee, and will identify the competencies that lead to successful leadership of the agency. The program will focus on developing leaders at the mid- to senior-levels, and will be synchronized with the HHS SES Candidate Development Program and the HHS University. Among the sources of feeder groups for the program will be former participants in the HHS Emerging Leaders Program, NIH Management Cadre, the Presidential Management Intern Program, and the NIH Management Intern Program. An initial evaluation of options and proposal of such a program will be prepared by the end of calendar 2002.

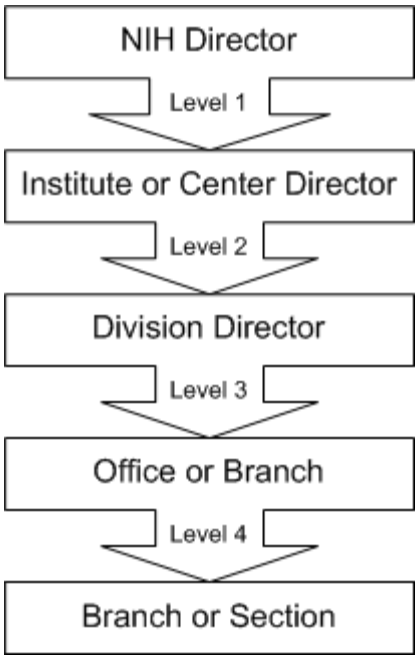
The proposal will include an evaluation of the following issues as well:

- Improving the current working environment to improve retention of staff with core skills, including the collection of information about why good employees leave;
- Succession plans to fill all managerial positions, even if the current manager is not planning to leave, including guidelines for selecting future leaders, and providing the necessary training, development and mentoring for them.
- Developing a proposal for a forecasting/succession planning component that is linked to the HHS EHRP and other NIH and HHS systems.

3. Organizational De-Layering

In compliance with Department instructions to limit organizational layering, NIH has analyzed its organizational structure to determine which

organizations need to be restructured. To meet the Department's goal of no more than four organizational levels between the top of the agency and the staff level, we adopted the following model:



We reviewed all organizational components of the NIH, and determined those that exceeded four organizational layers between the NIH Director and the staff level. Six components were found to exceed the limit:

- National Cancer Institute
- National Institute of Allergy and Infectious Diseases
- National Institute of Arthritis and Musculoskeletal and Skin Diseases
- Office of Research Services
- Office of Financial Management
- Office of Administration

All have devised plans to restructure and will be in compliance with the de-layering requirement before the end of FY 2003. Scientific staff affected by these changes will continue to lead research teams, but will not be burdened with supervisory duties. Administrative staff affected by these changes will be reassigned to non-supervisory duties.

For a more detailed account of plans and timetables in this area, see Appendix 3, Organizational De-Layering Plan.

4. Voluntary Early Out Retirement Authority (VERA)

NIH has obtained authority to use VERA as a tool in facilitating restructuring and competitive sourcing initiatives.

Initially, VERA will be offered to employees in the Human Resources function where consolidation is underway. There are approximately 113 employees in the GS-0201 and GS-0203 human resource series who will become eligible for Voluntary Early Retirement before October 1, 2003. It is anticipated that approximately 20 percent will accept Voluntary Retirement. As other administrative functions are consolidated, NIH will consider a similar use of VERA.

NIH also plans to use VERA to diminish workforce impacts in the A-76 process. As areas are identified for outsourcing, VERA will be offered to affected employees in order to facilitate these transitions.

5. Career Transition Measures

The NIH has carefully considered the impact that outsourcing, restructuring, and administrative reductions will have on its employees. The agency is prepared to provide career counseling and re-training, and to redeploy employees who choose to remain with the NIH. Appendix 4 is a draft (discussion) document that provides the most recent version of the NIH program to address these issues.

B. Employee Training and Development

1. HHS University

NIH is actively working with OS and other OPDIVs to create an HHS University. When implemented, the University will be a critical component of the NIH strategy to provide staff with the training and career development services necessary to eliminate any skills gaps. The University is expected to:

- Further the Secretary's goal of "One HHS" as well as support the human capital management components of the President's Management Agenda.
- Reinforce the strategic use of learning to further mission accomplishment.
- Create opportunities for economies of scale in a time of diminishing resources.
- Support life-long learning/knowledge management to meet challenges of a changing world.
- Enhance recruitment and retention efforts.

2. Continuing Emphasis on Training and Development

NIH will continue to provide training and career development opportunities through such venues as the FAES, the Clinical Research Training program, the Information Technology Training program, and the NIH Training Center.

NIH will examine current offerings and modify or expand them as necessary to provide training in critical skill gap areas including multi-disciplinary research, leadership, scientific education, mentoring, and information technology.

3. Emerging Leader and Other Internship Programs

NIH has a long tradition of supporting internship programs as a mechanism for developing key talent. However, with the impending demographic drain on the NIH leadership cadre, NIH is stepping up support of these programs.

a) HHS Emerging Leaders Program

NIH has made a substantial commitment this year to supporting interns in the new HHS Emerging Leaders internship program. NIH is supporting a total of 14 interns, in the following career paths: Information Technology (3), Administration (4), Public Health (5), and Science (2). The interns have begun their initial year at the Department where they will be exposed to high-level officials of the Department, introduced to the inter-relatedness of work within the operating divisions, provided an opportunity to gain a working knowledge of the various occupations and become familiar with the overall environment of the Department. They will spend the following year at NIH before being placed in appropriate professional positions with potential to develop into the technical and management leadership cadre of the future.

b) Presidential Management Intern Program (PMI)

The National Institutes of Health (NIH) has participated in the PMI program since 1985. We pride ourselves on offering interesting, challenging, and flexible opportunities. PMIs, along with their mentors, select rotations that are tailored to meet their individual career development goals and the needs of NIH. PMIs develop rotational assignments in a broad range of administrative and programmatic areas, including: Budget, Human Resources, Information Technology, General Administration, Contracts, Grants Management, Communications, Science Policy, Planning & Evaluation, and Legislation.

The PMI Program at NIH is unique in offering:

Mentors. Each PMI works closely with a mentor throughout the two-year internship. The mentor may provide advice on rotational assignments, training opportunities, and future career options.

Rotations. Rotational assignments may occur throughout NIH, as well as in other agencies of the Department of Health and Human Services, other Executive Branch departments, and Congress.

Training. Interns receive a training budget of $2000 per year to enhance their administrative and management skills and further their career development.

Professional Development Opportunities. Each class of NIH PMIs actively participates in individual and group professional development activities including Brown Bag Lunches, a Management Seminar Series (MSS), etc.

NIH can also boast a record of 100% placement of all NIH PMIs that choose to remain with the agency at the completion of the PMI program.

This year, NIH interviewed 65 PMI candidates and selected 15 new interns. Next year NIH is considering expanding the program to provide for a larger intern class.

c) Management Intern Program (MI)

The NIH Management Intern Program was established in 1957. The Program has graduated 350 interns since its inception. The NIH currently has 115 former interns on staff. The Program offers highly motivated HHS employees an opportunity to explore different administrative fields, gain invaluable insight into the NIH, and change careers. Graduates have become some of NIH's most respected administrative managers. Former interns are currently in a variety of NIH occupations, including Executive Officers and Administrative Officers, Budget Officers and Analysts, Deputy Director of Legislation and Legislative Analysts, Program and Management Analysts, Grants and Contract Management Specialists, Writers/Editors, Public Affairs Specialists, Human Resource Management

Specialists, EEO Officers and Specialists and Information Technology Specialists.

This year, NIH interviewed 53 candidates for the MI program and selected five new interns from that group. Next year, NIH is considering expanding the program to provide for a larger intern class.

C. Changes in Staffing Patterns

1. Targeted Corporate Recruitment to Fill Gaps

As part of restructuring its HR business process, NIH is preparing to implement a corporate recruitment program. At the top of the agenda for the new corporate recruitment group will be implementing recruiting initiatives to assure that staffing gaps identified in this plan are addressed. For example, the corporate recruitment staff will concentrate on recruiting Chemists in order to fill the gap currently projected in that occupation, recruiting additional scientists to carry out the expanded research agenda, recruiting behind key leadership staff who retire, recruiting additional clinicians to support the new emphasis on applying the harvest of information about the human genome to discovery of cures and therapies, recruiting science administrators with multidisciplinary backgrounds and collaborative skills, etc. The corporate recruitment staff will also undertake targeted recruitment efforts to maintain and enhance the diversity of the NIH workforce.

The new corporate recruitment office will include groups devoted to marketing and planning, senior level / SES recruitment, and centralized examining. Some details on the proposed functions of these workgroups are as follows:

Marketing and Planning

- Recruit a talented scientific, clinical and administrative staff
- Collaborate with IC EEO Officers to develop a corporate plan to enhance workforce diversity
- Disseminate information to academia, private organizations and the public about NIH career opportunities

- Identify hard-to-fill occupations and develop plans to address corporate needs
- Serve as consultants and advisors to IC Teams on various recruitment issues

Centralized DEU

- Shared examining procedures with IC Teams.
- Centralized recruiting for repetitive positions.
- Develop standing registers or standardize recruitment processes for commonly filled positions.
- Coordinate DEU quarterly reports required by OPM
- Serve as NIH Employment Center (e.g., accept applications, serve as information point of contact for walk in, call in, write in employment seekers.

Senior Level/SES Recruitment

- Responsible for recruitment activities for all SES positions, and all Institute/Center Director, Deputy Director, Scientific Director, and Clinical Director positions.
- All Senior Executive Service positions: Preparation of all documentation required for the approval of the SES search; advertising the position; review and interview process; and preparation of required documentation for the selection approval by the Director, NIH, Secretary, DHHS, and Office of Personnel Management.

2. Recruitment and Retention Strategy

NIH fully endorses the HHS Recruitment and Retention Strategy (Appendix 2). NIH is committed to implementing the actions prescribed in the strategy document in accordance with the timelines identified therein. As soon as the new corporate recruitment group is operational, NIH will develop a detailed plan for implementing the strategy including specific action steps and timeframes.

Appendix 1 – NIH Institutes and Centers

Institute/Center	ICs	Mission
Office of the Director	OD	OD provides leadership, focus, and direction to the NIH research community, and coordinates and directs initiatives that cross Institutes and Centers. The OD is responsible for the development and management of intramural and extramural research and research training policy, the review of program quality and effectiveness, the coordination of selected NIH-wide program activities, and the administration of centralized support activities essential to the operation of the NIH.
National Cancer Institute	NCI	NCI conducts and supports programs to understand the causes of cancer; prevent, detect, diagnose, treat, and control cancer; and disseminate information to the practitioner, researcher, patient, and public. The Institute's efforts are directed at reducing the burden of cancer morbidity and mortality, and ultimately, at preventing the disease.
National Heart, Lung, and Blood Institute	NHLBI	NHLBI's research program is directed at diseases of the heart, blood vessels, lungs, and blood and at transfusion medicine. Its activities encompass innovative basic, clinical, population-based, and health education research.
National Institute of Dental and	NIDCR	NIDCR's research program is directed at understanding, treating, and ultimately preventing the infectious and inherited

Institute/Center	ICs	Mission
Craniofacial Research		craniofacial-oral-dental diseases and disorders that compromise millions of human lives.

National Institute of Diabetes and Digestive and Kidney Diseases	NIDDK	NIDDK conducts and supports research, training, health information dissemination, and other programs with respect to diabetes millitus and endocrine and metabolic diseases, digestive diseases and nutritional disorders, and kidney, urologic, and hematologic diseases.
National Institute of Neurological Disorders and Stroke	NINDS	NINDS conducts and supports research and training on the normal and diseased nervous system in order to reduce the burden of neurological diseases. The research program is ultimately directed at improving the prevention, diagnosis, and treatment of the hundreds of disorders affecting the nervous system. Including stroke; epilepsy; demyelinating disorders such as multiple sclerosis; tumors; pain; traumatic injury of the brain and spinal cord; degenerative disorders such as Parkinson's disease; movement disorders; developmental disorders such as autism, the myasthenias and muscular dystrophies; and numerous autoimmune, metabolic, and genetic disorders.
National Institute of Allergy and Infectious Diseases	NIAID	NIAID conducts and supports research that strives to understand, treat, and ultimately prevent the myriad infectious, immunologic, and allergic diseases that threaten millions of human lives.
National Institute of General Medical Sciences	NIGMS	NIGMS supports basic biomedical research that is not targeted to specific diseases, but increases understanding of life processes and lays the foundation for advances in disease diagnosis, treatment, and prevention. NIGMS attempts to ensure the vitality and continued productivity of basic biomedical research, while producing the next generation of scientific breakthroughs and

		training the next generation of scientists.

National Institute of Child Health and Human Development	NICHD	NICHD conducts and supports research on fertility, pregnancy, growth, development, and medical rehabilitation. The Institute's broad purpose is to ensure that every child is born healthy and wanted, and grows up free from disease and disability.
National Eye Institute	NEI	NEI conducts and supports research, training, health information dissemination, and other programs that are directed at blinding eye diseases, visual disorders, mechanisms of visual function, preservation of sight, and the special health problems and requirements of the blind.
National Institute of Environmental Health Sciences	NIEHS	NIEHS conducts and supports research on how environmental exposures, genetic susceptibility, and age interact to affect an individual's health. Its overall purpose is to reduce the burden of human illness and dysfunction from environmental causes.
National Institute on Aging	NIA	NIA conducts and supports research on the biomedical, social, and behavioral aspects of the aging process; the prevention of age-related diseases and disabilities; and the promotion of a better quality of life for all older Americans.
National Institute of Arthritis and Musculoskeletal and Skin Diseases	NIAMS	NIAMS conducts and supports research, training, and information dissemination directed at understanding the normal structure and function of bones, muscles, and skin, as well as the numerous and disparate diseases that affect these tissues.
National Institute on Deafness and	NIDCD	NIDCD conducts and supports basic and clinical research and research training in the normal and disordered processes of hearing, balance, smell,

Other Communicatio n Disorders		taste, voice, speech, and language. These diseases and disorders currently affect some 46 million Americans. Basic and clinical research focused on understanding the normal processes and disorders of human communication are motivated both by intrinsic scientific interest and importance to the health of the nation.
National Institute of Mental Health	NIMH	NIMH conducts and supports research on the brain and behavior – basic, clinical, epidemiological, and health services research. The Institute's activities are broadly dedicated to understanding, treating, and preventing mental illnesses.
National Institute on Drug Abuse	NIDA	NIDA conducts and supports research across a broad range of disciplines that bear on drug abuse and addiction and disseminates information about its research findings. The Institute's broad purpose is to help reduce drug abuse and to improve the options for addiction prevention and treatment.
National Institute on Alcohol Abuse and Alcoholism	NIAAA	NIAAA conducts research directed at improving the treatment and prevention of alcoholism and alcohol-related problems. The Institute's broad objective is to reduce the enormous health, social, and economic consequences of this disease.
National Institute of Nursing Research	NINR	NINR has a broad mandate to sponsor research on the clinical care of individuals and their responses to health problems. Scientists supported by the Institute seek to understand and mitigate the effects of acute and chronic illness and disability, promote healthy behaviors and prevent the onset or worsening of disease, and improve the environment in which healthcare

		is administered.
National Human Genome Research Institute	NHGRI	NHGRI supports the NIH's participation in the Human Genome Project, a worldwide research effort directed at analyzing the structure of human DNA and determining the location of the estimated 100,000 human genes. At the intramural level, NHGRI develops technology for understanding, diagnosing, and treating genetic diseases.

National Institute of Biomedical Imaging and Bioengineering	NIBIB	NIBIB promotes fundamental discoveries, design and development, and translation of technological capabilities in biomedical imaging and bioengineering, enabled by relevant areas of information science, physics, mathematics, materials science, and computer sciences. NIBIB plans, conducts, fosters, and supports an integrated and coordinated program of research and research training that can be applied to a broad spectrum of biological processes, disorders and diseases and across multiple organ systems.
National Center for Research Resources	NCRR	NCRR advances biomedical research and improves human health through research projects and shared resources that create, develop, and provide a comprehensive range of human, animal, technological, and other resources. There are four main areas of concentration: biomedical technology, clinical research, comparative medicine, and research infrastructure.
National Center for Complementary and Alternative Medicine	NCCAM	NCCAM conducts and supports basic and applied research and training and disseminates information on complementary and alternative medicine to practitioners and the public.
National Center for Minority Health and Health Disparities	NCMHD	NCMHD serves as the focal point within the National Institutes of Health for planning and coordinating minority health and other health disparities research. The Center coordinates the development of a comprehensive health disparity research agenda that identifies and establishes priorities, budgets, and policy that govern the

		conduct and support of NIH-sponsored minority health and other health disparities research and training activities.
Fogarty International Center	FIC	FIC leads the NIH's efforts to advance the health of the American public and citizens of all nations through international cooperation on global health threats.

Warren Grant Magnuson Clinical Center	CC	CC is the clinical research facility of the NIH. It provides patient care, services, training and the environment in which NIH clinician-scientists creatively translate emerging knowledge into better understanding, detection treatment and prevention of human diseases.
Center for Scientific Review	CSR	CSR carries out initial peer review of the majority of research and research training applications submitted to the NIH. Peer review is the foundation of the NIH grant and award process. The Center also serves as the central receipt point for all Public Health Service applications and makes referrals to scientific review groups for scientific and technical merit review and to funding components for potential award.
National Library of Medicine	NLM	NLM is one of three national medical libraries. It collects, organizes, and makes available biomedical science information to investigators, educators, and practitioners. It also carries out programs to strengthen medical library services in the United States. NLM's electronic databases, such as MEDLINE, are used extensively throughout the world.
Center for Information Technology	CIT	CIT provides, coordinates, and manages information technology and seeks to advance computational science.
Office of Research Services	ORS	ORS' mission is to effectively and efficiently satisfy the diverse needs of the NIH research and research support efforts as they grow and change. This involves active stewardship of the NIH's facilities and environment; vigilant protection of the NIH staff, research animals, and physical assets; enhancement of community

		work life; and continuing transformation of the ORS into a best practice center for the provision of the research support and infrastructure needed at this complex biomedical research institution.

Appendix 2 – HHS Recruitment & Retention Strategy

RECRUITMENT AND RETENTION STRATEGY

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

MAY 2002

Recruitment and Retention Strategy
U.S. Department of Health and Human Services

Table of Contents

I. INTRODUCTION

The purpose of this Recruitment and Retention Strategy is to identify a framework for actions required to meet the Department's short and long-term workforce needs. It addresses recruitment of professional, administrative, and technical occupations; and targeted recruiting to maintain or improve the Department's workforce diversity. It also addresses entry-level recruiting and strategies to strengthen the Department's image on college campuses nationwide, tap into internal potential, and revitalize student education and employment programs that have proven successful in the past.

The Strategy also addresses workforce requirements related to retention. It looks at resignations, which pose at least as great a problem to workforce planning as retirements; and outlines strategies to respond to ongoing losses through resignation. It looks at current and projected retirement eligibility; and identifies strategies to address areas that could pose problems in the near future if not attended to now.

This Strategy is developed in the context of the *President's Management Agenda for 2002* and the Department's own current *Workforce Restructuring Plan*. Both of these documents stress the importance of human capital management. The *President's Management Agenda* identifies the need to make government programs more responsive to the American people and the requirement to make better use of flexibilities currently in place to acquire and develop talent and leadership. The Department's *Workforce Restructuring Plan* establishes three basic principles for shaping the HHS workforce: (1) managing HHS as one Department; (2) holding managers accountable; and (3) actively managing workforce change to avoid skills shortages and imbalances.

II. HHS WORKFORCE

Workforce data were reviewed for all HHS operating divisions (OPDIVs) as well as the Department-wide core occupations:

1. Nurse, GS-610
2. Medical Officer, GS-602
3. Health Scientist, GS-601
4. Biologist, GS-401
5. Consumer Safety Officer, GS-696
6. Chemist, GS-1320
7. Public Health Analyst, GS-685
8. Microbiologist, GS-403
9. Health Insurance Analyst, GS-107
10. Social Science Analyst, GS-101
11. Computer Specialist, GS-334
12. Program/Management Analyst, GS-343
13. General Administration, GS-301

These occupations are defined as core because they represent the occupations with the largest numbers of workers in the Department and because they are necessary to accomplish the programs for which the Department is responsible. Individual OPDIVs may identify core occupations that are unique to their own organizations.

The data cited herein and in the attached Workforce Data Analysis originate from the Department's Personnel Master File. To look at the most current workforce characteristics and trends, data from FY 2001 were used. To look at past characteristics and trends, data from Fiscal Years 1997 through 2000 were used. To project into the future, data through FY 2006 were used.

Workforce data from the present, the past, and the future reveal several important trends.

Size and Age of Workforce

The HHS workforce is growing and aging. Overall, the Department increased by 8.2% over the five-year period from FY 1997 through FY 2001. During this same period, the workforce aged--in FY 1997 34 percent of the population was 50 years of age or older and over 8.7 percent of the population was 29 years of age or younger. Today, over 39 percent of the population is 50 years of age or older and slightly over 7 percent of the population is 29 years of age or younger.

Workforce Diversity

The Department's percentage of minority employment is close to or better than the nationwide percentage of minorities aged 18 years or older. In looking at specific minority categories--Native American, Asian/Pacific Islander, African American, and Hispanic--the Department is meeting the nationwide percentage in most areas. The exceptions are:

Hispanic--their population is substantially below average in every OPDIV and for every core occupation.

Native American--Five of 12 OPDIVs are below average for Native Americans (AHRQ, FDA, NIH, PSC, and CDC/ATSDR), as are four of 13 core occupations (Microbiologist, Consumer Safety Officer, Biologist, and Chemist).

Asian/Pacific Islander--three core occupations fall short--Nurse, Public Health Analyst, and General Administration.

African American--six core occupations are below the average--Nurse, Medical Officer, Microbiologist, Chemist, Biologist, and Health Scientist. For the Nursing occupation in particular, the shortage may be due to the fact that IHS has over 67 percent of the Department's Nurses with a very large number of Native Americans. This may also be true to a lesser extent for Medical Officers, where IHS has almost 25 percent of the Department's workers in this occupation.

Retirement

The Department will, indeed, face a retirement bubble, and some OPDIVs are in trouble right now. By the end of FY 2001, only 13.68 percent of the Department-wide workforce was eligible to retire. However, in the Administration on Aging, over 33 percent are eligible now. There are similar retirement numbers for three Department-wide core occupations: over 26 percent for Consumer Safety Officers, and over 24 percent for both Chemists and Social Science Analysts.

By the end of FY 2006, 20,450 individuals, or over 31 percent of HHS's FY 2001 employees, will reach retirement eligibility. OPDIVs with the highest percentage eligible are AOA (58.91%) and ACF (57.69%); with SAMHSA (41.64%) and CMS (40.92%) not far behind. The core occupations with the highest percentage eligible to retire by the end of FY 2006 are Social Science Analysts (over 55%), Chemists (over 47%), Health Insurance Analysts (over 42%), and Consumer Safety Officers and Public Health Analysts (each with 38% or more eligible).

Turnover

The Department had relatively low annual turnover for most core occupations, with nine of 13 having had a turnover rate of 6.6 percent or less in FY 2001. Turnover was high, however, for Biologists (11.99%), Nurses (10.83%), General Administrators (9.37%), and Medical Officers (7.23%). Higher turnover for these occupations is more likely, since these offer plentiful opportunities throughout the labor market. These are also the types of occupations, however, that many OPDIVs project as being more important in the future.

In FY 2001, over half of turnover was due to resignations/transfers versus retirement for all core occupations. The worst cases were Medical Officer (92.41% of turnover from resignation/transfer), Biologist (91.61%), Nurse (85.71%), and General Administration (77.15%). These are the same core occupations with the highest turnover. OPDIVs have identified three of these four--Medical Officer, Nurse, and Biologist-- as increasing in importance in the future.

III. RECRUITMENT AND RETENTION STRATEGIES

The Department's Recruitment and Retention Strategy is intended to meet the organization's short and long-term workforce needs. It is based on workforce data that reflect the size, age, and diversity of the workforce; retirements; and turnover.

Four broad objectives are identified that reflect a logical sequence for action:

Objective 1: Lay the Foundation

A. Workforce planning, recruitment planning, and marketing.

B. Partner with professional, educational, and minority organizations.

C. Strengthen the college relations program.

Objective 2: Attract a Diverse and Skilled Workforce

A. Streamline the hiring process and give managers useful hiring tools.

B. Make student programs more productive recruitment tools.

Objective 3: Improve Retention

A. Strengthen orientation, mentoring, career management tools, and other approaches to increase staff productivity and retention.

Objective 4: Evaluate

A. Monitor and evaluate the Recruitment and Retention Strategy to assess results

Objective 1: Lay the Foundation

A. Workforce planning, recruitment planning, marketing

To recruit effectively, the Department must put increasing emphasis on a central message that reflects one central department and one central goal. This message must also emphasize the Department's central humanitarian mission and reputation as an important part of ensuring the health of Americans, in order to attract the best candidates.

The Department already has a good start in developing an effective central message because of its humanitarian purpose and nationwide reputation. The Department must leverage these advantages to build a centralized, compelling message.

Effective recruitment marketing includes other elements:

A focus on tangible and intangible working benefits. Many of the Department's intangible benefits are among the benefits that young job-seekers value: work that makes a difference, challenging assignments, flexible schedules, and telecommuting. Also, the Department's tangible benefits—its total compensation package—increase in competitiveness when considered as a whole.

Well-designed recruitment-related communications, such as recruitment brochures and videos, classified ads, and booths for job fairs and trade shows.

Exciting and informative vacancy announcements that are appealing to job-seekers and that provide understandable information, especially to those with no knowledge of the federal system.

Job-related web sites that are easy to navigate; contain comprehensive, easy-to-follow content; and are visually exciting.
Human resource staff and managers who understand recruitment. These individuals know how to sell the Department to prospective employees, can articulate the tangible and intangible benefits the Department offers, and understand the jobs for which they are recruiting.
Participation in job fairs, career fairs, and conferences for targeted groups.

The Department must pull together all of these elements in a coordinated approach to design and implement a powerful and effective recruitment marketing campaign.

Strategic Actions

Department Strategic Actions: FY 2002

Develop plans to ensure that the Department's human resources systems are integrated with planning, budgeting and accountability processes. Ongoing

Develop guidelines for recruitment marketing. September 2002

Evaluate the Department's employment web sites for prominence, ease of navigation, and effective content. Generate a list of improvements to be made. August 2002

Provide guidelines for workforce recruitment plans. September 2002

Work with OPDIVs on development of workforce planning and recruitment/retention plans. Ongoing

OPDIV Strategic Actions: FY 2002

Evaluate existing recruitment brochures for content, language, and design. September 2002

Evaluate OPDIV employment web site for prominence, ease of navigation, and effective content. Generate a list of improvements to be made. August 2002

Begin development of workforce planning and recruitment/retention plans, including examples of how to maximize the use of existing hiring flexibilities, and identification of core occupations, and identification of workforce needs. Ongoing

Department Strategic Actions: FY 2003

Develop training on recruitment marketing. Explore making this training mandatory for all HR and management staff that recruit new employees to the Department. February 2003

Identify all of the benefits of a job with HHS--tangible and intangible. Begin a program to include a focus on both types of benefits in all recruitment materials. December 2002

Make final decision(s) on changes and improvements to be made to the Department's employment web sites. Implement these changes and improvements. March 2003

Implement training on recruitment marketing. April 2003

Evaluate the language and content of vacancy announcements and identify problems or weaknesses. Prepare guidelines for content and language to be used throughout HHS. April 2003

OPDIV Strategic Actions: FY 2003

Implement program to include a focus on both types of benefits (tangible and intangible) in all recruitment materials, as well as effective recruitment marketing techniques. February 2003

Implement guidelines for content and language of vacancy announcements used throughout each OPDIV. May 2003

Submit workforce planning and recruitment/retention plans. October 2002

Department Strategic Actions: FY 2004 and beyond

Continue efforts for recruitment marketing. Ongoing

Continue training on recruitment marketing. Ongoing

OPDIV Strategic Actions: FY 2004 and beyond

Participate in training on recruitment marketing. Ongoing

B. Partner with professional, educational, and minority organizations.

Data show that the Department's percentage of minority employment is close to or better than the nationwide percentage for minorities aged 18 years or older. For specific minority categories--Native American, Asian/Pacific Islander, African American, and Hispanic--the Department is meeting the nationwide percentage, with these exceptions:

The Hispanic population is substantially below average in every OPDIV and for every core occupation.

Five of 12 OPDIVs are below average for Native Americans (AHRQ, FDA, NIH, PSC, and CDC/ATSDR), as are four of 13 core occupations (Microbiologist, Consumer Safety Officer, Biologist, and Chemist).

Three core occupations fall short for Asian/Pacific Islander--Nurse, Public Health Analyst, and General Administration.

For African American, six core occupations are below the average--Nurse, Medical Officer, Microbiologist, Chemist, Biologist, and Health Scientist.

In addition, an analysis of the workforce shows that the Department is not meeting goals for hiring persons with disabilities.

To improve overall workforce diversity in OPDIVs and core occupations, the Department will include diversity goals in recruitment planning. Achieving these goals will require targeted recruiting, the basis of which is long-term relationships with professional, educational, minority organizations that can serve as a conduit to minority candidates. The Department will also continue efforts to target persons with disabilities in recruitment.

(Note: IHS must be granted special permission to hire other than Native Americans. In the event that IHS seeks exemptions to Native American hiring, they must consider diversity issues in making these hiring decisions.)

Strategic Actions

Department Strategic Actions: FY 2002

Emphasize long-term workforce diversity goals for the OPDIVs, both by overall workforce and by core occupations. Ongoing

Continue efforts to target persons with disabilities in recruiting. Ongoing

OPDIV Strategic Actions: FY 2002

Identify professional, educational, and minority organizations that may be useful for helping to achieve long-term workforce diversity goals. Begin outreach efforts with these organizations. September 2002

Department Strategic Actions: FY 2003 and beyond

Review OPDIVs' workforce diversity goals and provide feedback, as necessary. Ongoing

Continue outreach efforts with professional, educational, and minority organizations. Ongoing

OPDIV Strategic Actions: FY 2003 and beyond

Include workforce diversity goals in recruitment plans. January 2003

Continue outreach efforts with professional, educational, and minority organizations. Participate in their conferences and recruitment events. Ongoing

C. Strengthen college relations programs.

HHS faces the challenge of an aging workforce. In FY 1997 34 percent of the workforce was aged 50 or older; today it's 39 percent. In FY 1997 almost 9 percent of the workforce was under age 29; today it's slightly over 7 percent.

In fiscal year 2001, the permanent workforce in the Department averaged just over 46 years of age. Over the next 5 years, over 31 percent of the workforce is eligible to retire. To avoid a workforce crisis, the Department must strengthen its college relations program and begin an aggressive campaign to recruit entry-level employees.

Strategic Actions

Department Strategic Actions: FY 2002

Identify a college relations officer who will provide a Department-wide strategy for implementing a college relations program that includes establishing relationships at targeted schools. Identify a centralized resource to assist OPDIVs in identifying targeted colleges and universities, providing centralized activities where appropriate, and promoting coordinated college relations activities among OPDIVs where appropriate. September 2002

OPDIV Strategic Actions: FY 2002

Identify an OPDIV college relations officer to coordinate strategy for improving college relations and recruiting efforts. September 2002

Department Strategic Actions: FY 2003

Promote coordinated college relations activities among OPDIVs. Ongoing

Develop a speakers' bank or lecture series, coordinating with colleges and universities to increase exposure of HHS and the work of the OPDIVs in these institutions. May 2003

Implement speakers' bank or lecture series. September 2003

OPDIV Strategic Actions: FY 2003

Identify colleges and universities that align with OPDIV recruitment goals for core occupations and workforce diversity. January 2003

At targeted colleges and universities, begin efforts to develop long-term, continuing relationships by making key contacts and developing schedules/making plans to: (1) participate in career fairs; (2) present employer information sessions; and (3) participate in on-campus recruiting. March 2003

Begin to establish or strengthen relationship with college placement officers. March 2003

Begin efforts to involve OPDIV subject matter experts in representing their disciplines. May 2003

Begin efforts to work with targeted colleges/universities to improve Department cooperative education/intern programs to attract students. March 2003

Work with Department speakers' bank or lecture series to provide speakers to present at colleges and universities. June 2003

Department Strategic Actions: FY 2004 and beyond

Promote coordinated college relations activities among OPDIVs. Ongoing

Promote use of speakers' bank or lecture series at participating colleges and universities to increase exposure of HHS in these institutions. Ongoing

Objective 2: Attract a Diverse and Skilled Workforce

A. Streamline the hiring process and give managers useful hiring tools.

In discussions with HHS managers, it is clear that the Department needs to streamline hiring and give managers useful hiring tools. Today, the number one factor in recruiting success is the recruitment process--is it simple, is it fast, is it flexible? Accordingly, a key Department strategy is to improve the hiring process, streamline the hiring process, and give managers useful hiring tools. This would include:

Simplify and standardize the application process. Two or more documents are required of applicants: a resume and narrative addressing the job's KSAs. In some cases, other documents are required. To increase the number of individuals who will apply for HHS jobs, the Department must simplify and standardize the application process. Ideally, this would eliminate the separate KSA narrative.

Evaluate and implement approaches to streamline the hiring process. The recruitment cycle time--from advertising the vacancy to making a final offer--takes three months or more for most jobs. This drawn out process won't work in an environment where private

sector organizations are measuring their recruitment time in days or weeks. Many requirements unique to the federal government slow the process. However, much of the cycle time can be shortened by approaches that HHS HR offices are already using. These include the use of open continuous announcements and web-based and automated applications.

Improve feedback/response to applicants. To maintain a solid reputation and to keep qualified applicants interested in the vacancy, the Department must provide timely feedback on the status of the individual's application for every vacancy and applicant. This could be accomplished by a standardized post card or e-mail.

Use existing flexibilities more effectively. OPM has authorized several flexibilities designed to improve a federal organization's ability to attract and retain individuals in hard-to-fill occupations. HHS makes little use of these flexibilities. Many officials in the Department explain that they do not have the available money. One HHS office that uses the flexibilities explains that they have the funds because they offer the bonus when the position has been vacant for a while, so that funds that would have covered salary can be used. Others are concerned that bonuses to select individuals will create internal inequity. In some cases, though, the risk of internal inequity may be outweighed by business need.

Make use of employee referral bonuses. Organizations that use employee referral bonuses have found them effective and inexpensive recruitment tools. When an employee refers a candidate, the employee has determined that he/she will fit into the organizations' culture, so that the candidate usually works well in the organization. OPM is now in favor of employee referral bonuses.

This strategic objective could be most effectively achieved by designing and implementing an automated recruiting and staffing system. In addition, there are areas where the Department now has the authority to act. There are other areas, however, where the Department is restricted by law or higher-level policy. The "rule of three" in hiring is one. Another is the constraint on who can be considered for entry-level recruiting.

These areas must also be addressed if HHS is to fully streamline the hiring process and give managers useful hiring tools.

Strategic Actions

Department Strategic Actions: FY 2002

Begin to evaluate the feasibility and usefulness of implementing an automated recruiting and staffing system. September 2002

Identify laws and OPM policies that are impediments to the hiring process. June 2002

Evaluate new technologies that can be used to reduce the time required for hiring. Ongoing

OPDIV Strategic Actions: FY 2002

Evaluate and advise on specific approaches to use to streamline the hiring process, and provide for timely feedback to applicants. September 2002

Department Strategic Actions: FY 2003

Implement program for awarding employee referral bonuses. February 2003

Begin development of a Department-wide automated recruiting and staffing system, which will streamline the hiring process, reduce the time required for hiring, and provide for timely feedback to applicants. January 2003

Hold discussions with OPM regarding provisions or personnel laws that are impediments to a streamlined hiring process and to effective recruitment. Continue to work, as necessary, to accomplish changes. November 2002

OPDIV Strategic Actions: FY 2003 and beyond

Implement program for awarding employee referral bonuses. February 2003

Implement standards and approaches which will provide for timely feedback
to applicants. January 2003

Department Strategic Actions: FY 2004 and beyond

Pilot test automated recruiting and staffing system. November 2003

Fully implement automated recruiting and staffing system. March 2004

B. Make student programs more productive recruitment tools.

For many years, the federal government used a variety of student programs to fill entry-level positions with highly qualified candidates. These programs were abandoned in the 1990s for a variety of reasons. Agencies that used these programs, though, can attest to their effectiveness.

HHS has already determined that a Department-wide career intern program is a vital component of a recruitment and retention strategy, and has implemented the Emerging Leaders Program. The Department can use this program to attract exceptional men and women to the Department who have diverse professional experiences, academic training and competencies, and prepare them for careers in analyzing and implementing health and social services programs. Through an aggressive recruitment effort, the Department can seek the highest caliber people for entry level positions, expose them to all OPDIVs through rotational assignments, set high expectations for self-learning, and closely monitor their progress in a formal two-year training period. The Department can expect a great return on investment.

In addition to the Emerging Leaders Program, the Department will implement a student recruitment initiative. Each year, the Department hires nearly 2,000 students through various school programs, fellowships, internships, and summer appointments. Most of these students are successful in their short-term jobs with HHS and are good candidates for permanent jobs--employees who have experience with the Department and would like to return. Yet, in the past the Department has allowed these potential future employees to finish their programs without actively recruiting them. Accordingly, HHS will begin to target current student employment as a prime recruiting source.

Strategic Actions

Department Strategic Actions: FY 2002

Develop Emerging Leaders Program to recruit talented young professionals to the Department to address recruitment needs. April 2002

Develop a broad structure for the Department-wide Emerging Leaders Program. Address approach for managing interns, nature and length of rotational assignments, standards for learning objectives, approaches for monitoring progress, standard(s) for successful completion of program, methods for developing a sense of community among interns, and process for converting intern to permanent employee and assigning to initial job. July 2002

OPDIV Strategic Actions: FY 2002

Provide input and support to Department plans for Emerging Leaders Program and student recruitment. July 2002

Department Strategic Actions: FY 2003 and beyond

Develop approaches for implementing an initiative to actively recruit current students and interns into permanent government service. Consider establishing a database to track students. November 2002

Implement approaches for the student recruitment initiative. May 2003

OPDIV Strategic Actions: FY 2003 and beyond

Continue to provide input and support to the Department student recruitment initiatives. Ongoing

Implement student program initiatives within the OPDIV. May 2003

Objective 3: Improve Retention

A. Strengthen orientation, mentoring, career management tools, and other approaches to increase staff productivity and retention.

Workforce data show that over the next five years the Department could lose as many as 28,000 employees from retirements and resignations. To meet the growing demands on the public health and social services, the Department must recruit new staff members and bring them up to speed as quickly as possible. This makes rapid integration approaches--orientation, mentoring, and career management--critical.

The 22,000 who could leave through retirement are primarily senior staff. Candidate development programs are important for quickly developing the Department's leaders of the future.

Retirements in the Department, however, do not tell the whole story. Resignations pose at least as great a problem to workforce planning as retirements. In FY 2001, over half of turnover was due to resignations/transfers versus retirement for all core occupations. The worst cases were those same occupations that HHS managers indicate are growing in importance: Medical Officer (92.41% of turnover from resignation/transfer), Biologist (91.61% of turnover from resignation/transfer), and Nurse (85.71% of turnover from

resignation/transfer). The Department must understand why these individuals are leaving and devise approaches to increase retention of these critical staff members.

Strategic Actions

Department Strategic Actions: FY 2002

Implement HHS-wide orientation program. February 2002

Design pilot program for new employee mentoring. August 2002

Commission a study to identify factors that influence why individuals stay in a job. August 2002

Begin development of pilot program for exit interviewing as a way to identify reasons staff resign from their jobs at HHS. June 2002

OPDIV Strategic Actions: FY 2002

Review existing OPDIV-level orientation programs and make changes to update and improve effectiveness; or initiate OPDIV-level orientation program as necessary. July 2002

Department Strategic Actions: FY 2003

Implement pilot program for new employee mentoring. December 2002

Disseminate results of study to identify factors that influence why individuals stay in a job. March 2003

Implement pilot program for exit interviewing. Evaluate results, make appropriate changes and implement Department-wide. January 2003

Develop strategic approaches to retaining employees with critical expertise and competencies. May 2003

Develop career management program for the Department to consist of career pathing, career planning, and career advancement. This program should provide guidance to employees on how to navigate the system from entry-level, to senior specialist, to management, and should increase opportunities for employees to stay within the same agency or within the Department. March 2003

Implement candidate development program for Department during FY 03.

OPDIV Strategic Actions: FY 2003

Assess the OPDIV's current workforce to identify core and technical competencies. Ongoing

Implement new/improved orientation programs. November 2002

Implement new employee mentoring. March 2003

OPDIV Strategic Actions: FY 2004 and beyond

Utilize workforce competency assessment to identify current and projected future competency gaps between those of the current workforce and critical skills needed to accomplish the mission of the OPDIV. Ongoing

Objective 4: Evaluate

A. Monitor and evaluate the Recruitment and Retention Strategy to assess results.

The Department has in place a system to track restructuring initiatives. To minimize costs and maintain visibility , this same system will be used

to monitor and evaluate results of this Recruitment and Retention Strategy.

Success will be determined by the degree to which we accomplish our basic needs as indicated from analysis of our workforce data:

Improve diversity in the workforce, especially increasing the percentage of Hispanics among OPDIVs and core occupations.

Reduce turnover due to resignation, especially among those core occupations where there is a tight labor market and where opportunities in the marketplace are plentiful.

Increase entry-level and external hiring.

Increase internal recruitment to ensure that staff impacted by restructuring are redeployed to core mission and service delivery positions.

Decrease the overall age of the workforce.

Address the leadership vacuum that will result if many of the senior staff retire when they are eligible within the next five years.

Achieve management accountability by succeeding in getting management actively involved in the full range of recruitment activities, from planning to recruiting and hiring to evaluating for results.

Strategic Actions

Department Strategic Actions: FY 2002

Develop elements of system to monitor and evaluate the Recruitment and Retention Strategy to assess results. System elements should be part of the larger system that has been put in place to track restructuring initiatives.

Department Strategic Actions: FY 2003 and beyond

Begin to use system to monitor and evaluate the Recruitment and Retention Strategy. Issue annual report card of results.

Appendix 3 – Organizational Delayering Plan

National Cancer Institute

Office of Communications
Division of Extramural Activities
Division of Cancer Epidemiology and Genetics
Division of Cancer Treatment and Diagnosis
Center for Cancer Research, HIV Drug Resistance Program

Plan: Abolishing sections below level 4 and rolling these up into existing branch or laboratory structures.

Completion date: No later than October 1, 2002.

National Institute of Allergy and Infectious Diseases

- Division of Acquired Immunodeficiency Syndrome.

Plan: Abolish two sections.

Completion date: By June 30, 2003.

National Institute of Arthritis and Musculoskeletal and Skin Diseases

Intramural Research Program.

Plan: Abolish five sections in the Office of the Clinical Director. Transfer staff from the sections to the next higher layer.

Completion date: By the end of September 2002.

Office of Research Services

Delayering Timeline:

Week of 8/4: Announce pending reorganization study to ORS, NIH management, and union representatives.

Week of 8/12: Name a working group of ORS management and union to oversee process.

Mid-August/September: Develop underlying assumptions and premises for future ORS that guides plan.

During September: "Negotiate" union's role in the study.

During September: Working group will develop alternatives for consideration at offsite meeting (to be held 11/6-8).

Week of 11/6-8: At offsite meeting group will agree on the future structure of ORS.

Week of 11/18: Lay out agreed upon structure and brief OMA for agreement and support.

Mid-November-February/March: perform position gap analysis, develop any new PDs, etc., that might be required, perform impact studies.

April: develop reorganization package for submission to OMA.

May: submit final reorganization package to OMA.

Office of Financial Management

Financial Services Branch

Plan: Reorganize by removing the Deputy Assistant Director for Finance level.

Completion date: October 1, 2002

Office of Administration

Office of Acquisition Management and Policy
Office of Management Assessment

Plan: Abolish 4 branches; reassign staff to the higher level.

Completion date: By October 31, 2002.

Draft—August 12, 2002

Appendix 4 – NIH Transition Plan for Employees Affected by Restructuring

I. Background

The NIH is facing an unprecedented challenge as a result of restructuring activities that seek to improve government performance by shifting resources to core activities. These restructuring activities fall under several high visibility programs that are part of the President's Management Agenda or Secretarial initiatives to improve governance and resource management in the Department of Health and Human Services. Each of these activities will affect the staff associated with the program. The totality of the impact has the potential to affect over 3,400 NIH staff members.[1]

These issues were first raised in the steering committee overseeing the NIH implementation of the FAIR Act and subsequent cost-comparisons under OMB Bulletin A-76.[2] A draft paper that was developed for the steering committee was circulated to the IC Executive Officers and OD/OM Office Heads, and the issues were discussed broadly at a June 24, 2002 retreat of Executive Officers and Office of Management Office

[1] See Attachment 1 for a summary of how this figure is reached.

[2] Members of this group are Charles Leasure, Chair, Tom Hooven (NICHD), Bill Fitzsimmons (NIMH), Leonard Taylor (ORS), Don Christoferson (NHLBI), Maureen Gormley (CC), Patricia Abell (NCI), Leamon Lee (OD), Lawrence Self (OD), David Ramos (OD), Diane Frasier (OD), and Steve Benowitz (OD). Staff support is provide by the Office of Management Assessment (Tim Wheeles, Tom Fitzpatrick, and Ricardo Gomez).

Heads. Subsequent to the retreat, a representative group of IC and OD/OM managers volunteered to pursue the topic, develop options and recommendations, and submit them to the full Executive Officer group for further discussion. This transition plan is the result of that process. Its purpose is to describe the impact these changes will have on employees, the options the NIH has to address these changes, and recommendations on how to proceed. The issues addressed in this document must also be incorporated into the NIH Strategic Workforce Plan, to ensure that the organization's hiring, development and skills analyses consider the impact on employees of all restructuring efforts.

II. Impact of the Changes

The drivers for this initiative come primarily from the President's Management Agenda and its implementation within DHHS. The Agenda includes strategic management of human capital, including delayering to focus greater resources in program areas, and consolidation and subsequent savings in administrative functions (DHHS has made a commitment to reduce administrative positions by 700 FTEs by the end of FY 2003). In addition to administrative consolidation, we must move to 4 layers of management (starting with the IC Director or OD Deputy Director levels). Information from the Office of Management Assessment indicates that there are as many as 92 sub-organizations spread over four Institutes and the Office of Management/Office of the Director, that go beyond the 4th level of management.[3] Assuming that these sub-organizations will be eliminated from the formal organization structure, there are implications for individuals managing these units.

The Agenda also addresses competitive sourcing. To achieve a "green light" in this item, an agency must complete cost-comparisons between the current cost (performed by government employees) and costs if outsourced for 50 percent of the agency's "commercial" positions by the end of FY 2005. At the NIH, there are nearly 9,300 commercial positions;

[3] These organizations are at the lowest level within the Institute or Office of Management. It is possible to eliminate a higher level of management, still reach an overall level of four, but have fewer sub-organizations to eliminate.

cost-comparisons must be completed on 5 percent of these positions by the end of 2002; on an additional 10 percent in 2003; 10-15 percent in 2004; and the remainder in 2005 (20-25 percent). This will result in a total of approximately 4,650 positions being evaluated. It is not possible at this stage to estimate the number of positions where the private sector might win a competition.

Technology promises to change the way that much work is performed at the NIH. For example, the implementation of IMPAC II is beginning is having an effect on the number of grants management staff (specialists and assistants) needed as some functions are automated. The NIH Business and Research Support System (NBRSS) is likely to eliminate some functions, create new opportunities, move functions from ICs to central units, and require higher level analytical skills from some employees. The staff involved with grants administration and the functions that are under the NBRSS umbrella is very substantial. While it is too early to predict the overall impact, we know these will occur and must plan for these changes.

III. Principles

Before proceeding with decisions on how to address the issues raised by restructuring, stakeholders should agree on the underlying principles that will govern this process. The following principles are proposed.

The issues are ones that can best be resolved if they are addressed on an NIH-wide level. There are several underlying reasons for this: organizations and employees in all Institutes and Centers may be affected; there is likely to be a larger impact on central services organizations, which are funded by all ICs; the complexity of the issues argues for a coordinated approach.

As specific organizations or functions are identified for restructuring, consideration should be given to controls on hiring, promotions and reassignments, pending the outcome of restructuring studies and decisions. This will leave the organization in the best possible situation to absorb the impacts of restructuring, including placement of affected

employees. The hiring plans for all ICs should be constructed in a way that incorporates overall NIH strategies for restructuring, so as to preserve flexibility to address the HR impacts.

Decisions made concerning the HR impacts of restructuring should be made only after considering the organizational and mission impacts of the decisions. Decisions should further the scientific research mission of the NIH, while addressing needs of affected employees in a supportive fashion.

Leaders of affected organizations should communicate with employees as early as possible about possible restructuring. In addition, there should be a broader, NIH-wide effort to communicate these issues with employees.[4]

A written policy addressing the level of support for career guidance should be developed. NIH should commit to a minimum level of retraining, and placement within the NIH, DHHS, other Federal agencies or outplacement to the private sector. This policy should also address whether and how the NIH will review IC vacancies for possible placement of affected staff.

IV. Options and Recommendations to Address the Changes

Issue: Whose Problem Is This?

There is agreement among the working group that the HR issues related to restructuring must be viewed as an NIH issue, and that the best resolutions can be found only through a collaborative approach among the stakeholders. This is also consistent with the DHHS view of workforce planning, which incorporates a strategic perspective to address these issues. Because the impact of any one of the drivers will affect all ICs (e.g., administrative restructuring, A-76) or multiple organizations (e.g.,

[4] The communications strategy of the human resource management restructuring serves as an excellent example of how such a strategy might work.

delayering), all ICs are being affected by the changes. While it is best for an IC to try to make some necessary accommodations internally to assist affected employees (e.g., retraining or reassignment), the potential scale of the changes will mean that all ICs will eventually be involved, and would benefit from an NIH-wide approach. In addition, the working group cannot stress enough the need for "top down" direction on this issue, to ensure that ICs understand the commonalities involved and the need for a collegial approach, and that employees have the greatest possible assurance that NIH, and not just their own IC, has a corporate approach and is providing support.

Issue: Communicating With Employees

A basic tenant of change or transition management is to communicate frequently with the stakeholders. NIH has done an excellent job of keeping HR staff informed and involved in the restructuring of that function. They have used a variety of tools, including all hands meetings, focus groups with affected HR staff and managers throughout the organization, and an interactive website. This was accomplished through a "communications subcommittee," a model that can serve the need well in the larger context we are addressing.

The working group also strongly endorses the need to communicate to potentially affected employees as early in the process as possible. This will require an effective communication plan that balances several competing concerns: keeping employees informed; allowing employee contributions to the process (and, in the case of A-76, participating in the bid process to keep the work in-house), communicating in a way that will not start a mass exodus of good employees before restructuring decisions are made.

The working group recommends that a formal communications process be incorporated into the plan. The working group would support the creation of a small group to perform this function on a full-time basis, because we believe the need is high and will continue for the next several years. Individuals would be selected from administrative functional areas, and given special training in communications and transition management. Alternatively, we could identify a small group of individuals who will focus

their efforts on communications. These employees could be drawn from the affected functional areas, and serve in a part-time basis while continuing their permanent positions. While this might serve NIH well, the issue is of significant substance, and could benefit from the full time effort of several employees who have or who would receive specialized training in this area.

V. Issue: Retraining and Redeployment of Affected Staff

There are a number of components to this issue, and each will be addressed separately. Where there is a consensus among the working group, there is a clear recommendation on how to proceed. In some areas the working group believes that additional discussion will be necessary before a recommendation can be made.

VI. What is the DHHS/NIH Commitment to Affected Staff?

The Secretary has clearly stated that all employees affected by restructuring "will have a job." Recently NIH has come to understand that this does not necessarily mean a job at NIH, or even DHHS or the federal government. It also includes the possibility of a job with a contractor, if a function is outsourced. [5] Alternatively, an employee may choose to leave voluntarily, and the availability of voluntary early retirement may provide some incentives for affected employees who are not yet eligible for

[5] What is not clear is whether DHHS will allow use of reductions-in-force to accompany outsourcing. While a drastic measure, in some cases it may benefit employees. For example, if an employee is eligible for early retirement, s/he could use the voluntary early retirement authority recently received by DHHS. However, if ineligible, an employee whose position is abolished is eligible for severance pay. Severance pay is based on the employee's years of service, and, to a lesser extent, age, up to a maximum of one year's salary. This may be a useful incentive if buyouts do not become available.

voluntary retirement. [6] The steering group believes that this broader understanding of the commitment must be shared with affected employees, but only in conjunction with a formal program to help employees through this transition.

VII. Career Counseling and Outplacement

The working group believes that an aggressive outplacement program [7] is an essential component of the program. The program should provide assistance from a trained staff and cover skills assessment, preparation of resumes, training in job-hunting skills, interviewing skills, and related assistance. Further, we strongly believe that the assistance should include active identification of positions outside the agency and pairing of affected NIH employees with these positions. This raises a sensitive issue of whether this will create the perception that NIH is using appropriated funds to identify employees for the private sector. However, there is some precedent for this. In the recent past, some programs in the Department of Interior were closed, and DoI used private sector firms to provide this full range of outplacement services for its staff. If deemed advisable, NIH could seek a legal opinion from the Office of General Counsel on the use of appropriated funds for this purpose.

NIH currently has the services of two FTE equivalent positions in the Work and Family Life Center where the individuals are capable of providing this support. However, their workload encompasses far more than career guidance and outplacement. The Office of Human Resource Management requested additional funds in 2003 for this purpose from the OD CSAC and the FARB. The FARB considered the request, and requests from other organizations for funds to address these issues, and recommended

[6] Voluntary early retirement is available to employees who are at least 50 years old and who have at least 20 years of federal service, or to those at any age who have at least 25 years of federal service. Employees under the Civil Service Retirement System taking VERA accept a lifelong reduction in their annuity of 2 percent a year for each year under age 55 (employees under FERS do not). However, this is offset to some extent by the cost-of-living adjustments built into the civil service retirement system.

[7] We define this as assistance in placing employees in organizations outside the NIH, to include both the public and private sector.

the inclusion of $2 million in the Management Fund reserve for 2003 to cover all aspects of restructuring. [8]

Because the cost of providing career counseling and outplacement assistance is substantial, and because we believe that the need for these services will be at least medium-range (3-5 years) if not longer, the working group recommends a mixed approach to staffing and funding the service. We believe that additional support will be needed immediately, and that the best alternative in the short run is to expand the contractor assistance. [9] However, because of the continuing need for this support, we recommend that two or more staff currently in administrative positions that may be affected by restructuring be reassigned to new duties to provide this support. This will involve a commitment of time and dollars (salary and training) to provide appropriate training. However, if the individuals are carefully selected we believe that NIH would have a cadre of employees available within one year to provide these services. At that time, we can reduce our contract obligations for the services. As such, we view the additional costs to NIH as short-term (contractor costs and training costs for reassigned employees).

VIII. Retraining and Redeployment of Affected Staff

The working group did not reach consensus on the extent to which NIH should support retraining and redeployment of affected staff. In part this was the result of not knowing the full costs that would be associated with some options. There was unanimity, however, in developing a proposal that would provide some level of support and mechanisms to assist in the placement of affected staff.

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[8] The OHRM request was for $320,000, or $160,000 for each of two contractors. This amount includes all fees associated with the contract with Vantage Human Resource Services. The FARB recommendation also includes the costs of contractors to conduct cost-comparison studies under A-76 and retraining for affected employees.

[9] The working group believes the current work of the career counseling staff is important, and that the resources currently in use should continue to be directed at the broader assignments now in play.

If funds were readily available, the working group would likely support the creation of a centralized program where affected employees would be assigned, their skills analyzed and compared to expected vacancies across the NIH, and then enter a re-training program to prepare them for these jobs. Described as the "NIH Future Team" by the working group, the full support for these individuals would be centralized—salaries and benefits, training, and placement elsewhere in the NIH. While agreement was not reached on the maximum timeframe employees could remain in the program, a program with a maximum of one year would have the following costs:

Salary costs (assuming average salary of GS-12 Step 3 plus benefits of 25 percent): $74,260 per employee per year.
Allowance for retraining costs (dependent on type of training and assuming that on-the-job assignments will be used in addition to formal training): $5,000 per employee per year.

Costs to administer the program (2-3 professionals reassigned from other administrative areas affected by restructuring for every 100 employees in the program): $74,260 per year per employee. [10]

Total yearly cost of the program for every 100 employees (excluding the career counseling noted above) is estimated to be $8.15 million.

Recognizing the sizeable amount that this full commitment would entail, the working group suggests some alternatives. Because the salary and benefits costs are likely to affect all ICs, those costs could continue to be covered by the IC for the one-year period of retraining. However, we recognize that central services programs may not have the budget flexibility to absorb the full cost at the same time that the function has been consolidated or outsourced. The central service organizations should make an explicit request for additional funds in this event, and we would endorse temporary increases in funding allocations when these organizations demonstrate that there are no other alternatives available. If the central commitment excludes the salaries of the affected

[10] The working group does not view this cost as a new investment. Rather, it is a redeployment of staff currently working at NIH.

employees, the year cost for every 100 employees would be approximately $723,000 (program administration and training costs).

The working group discussed but did not agree on whether affected employees could enter the retraining/redeployment program only if they agreed in writing to a set of behaviors expected of their participation. These behaviors fell into two categories. The first includes accountability and performance—giving participants a limited period of time to complete formal and on-the-job training and come to a fully successful performance level in the targeted position, and agreement to taking on during the re-training period short-term assignments not necessarily related to their identified long-term work goal (e.g., filling in for employees on leave or while vacancies in other functions are filled, so ICs can avoid use of contractor services for short-term needs). The second is the requirement that participating employees must sign an agreement to leave the NIH voluntarily at the end of the commitment if they are not able to obtain another permanent job at the NIH. The group likely would agree to the first (and similar) behavioral standards, but would be less likely to agree to the second. [11]

The issues surrounding placement of affected staff are likely to prove the most complex of all. As a basic premise, the group believes that retraining and reassignments must focus on positions for which there is a mid- or long-term likelihood of stability, i.e., that these jobs will not be restructured or eliminated in the foreseeable future. The NIH hiring plans for the next two years (FY 2003 and 2004) should be used as a beginning for identifying possible retraining and placement options. The working group is operating under the instruction that ICs must first try to place affected staff within their own programs. Because this would affect all ICs in the same fashion, or be spread across user ICs in the case of central service organizations, the approach is consistent with the objectives of the working group. When ICs are unable to place staff or the central services costs are too substantial, we must have in place a program to redeploy affected staff.

[11] The working group would recommend obtaining legal counsel on whether the second standard could be enforced.

The working group believes that there should be an NIH policy in this regard. This would require that there be an individual or organization charged with determining whether an IC has made an adequate attempt to place the individual internally. If so, then the affected employee would become eligible for the NIH placement program. Individuals with administrative responsibility for the program should continually examine the NIH workforce and hiring plans, and identify potential opportunities for participating staff. They should contact appropriate IC or HR officials, obtain the detailed qualification requirements for the position, and compare them to those of the participating staff. ICs should be required to fill the positions from within the group of participating employees or submit a written objection to the individual or organization noted above.

We recommend that the Deputy Director for Management, or his/her designee (e.g., NIH Director of Human Resources) be responsible for making these decisions. NIH policy should be that no administrative position vacancies may be advertised or filled from outside the IC until the IC has received the required clearance. [12]

Issue: Other Tools That May Help

The working group encourages judicious use of the voluntary early retirement authority. VERA should be used not only for those employees affected directly by restructuring, but in other instances where an employee might leave a position not subject to restructuring, and make available an opportunity for an employee who is affected. In the latter case, the NIH Office of Human Resources should ensure that the positions are backfilled only by employees affected by restructuring.

Issue: Evaluation

This program should be evaluated on a continuing basis. The task should fall to the new Office of Human Resource Management, HR Performance Assessment Staff. If the program should be changed, the Director of

[12] The centralization of the NIH HR function on October 1, 2002 will make the review process easier and more seamless.

Human Resources should consult with the Executive Officers and submit proposed changes to the Deputy Director for Management.

Attachment 1

Known Potential of Employees Affected

Program	Number Potentially Affected
A-76	4,658 positions to be studied 2,550 positions potentially outsourced
HR Restructuring	55-70
Transfer of public affairs staff to OS	368
Transfer of legislative staff to OS	13
Transfer of facilities staff to OS	502
Total	3,488 – 4,003

Appendix 5 – NIH A-76 2003 Review Functional Areas

NIH A-76 2003 Review Functional Areas (Also includes additional FTE which will apply to 04 reviews)

FTE	OMB Function Category
136	B000
21	B200
4	B302
13	B401
44	B501
16	C000
5	C100
4	C306
1	C404
5	E000
32	G210
73	L000
6	L100
2	L200
107	R000
233	R103
129	R140
74	R200
3	R600
21	S000
40	S200
24	S732
3	S733

9	S739
10	S753
1	S999
9	T710
61	T807
1	U500
53	W000
10	W499
34	W500
98	W601
21	W825
209	W826
74	W829
14	Z148
6	Z199
13	Z993

161
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